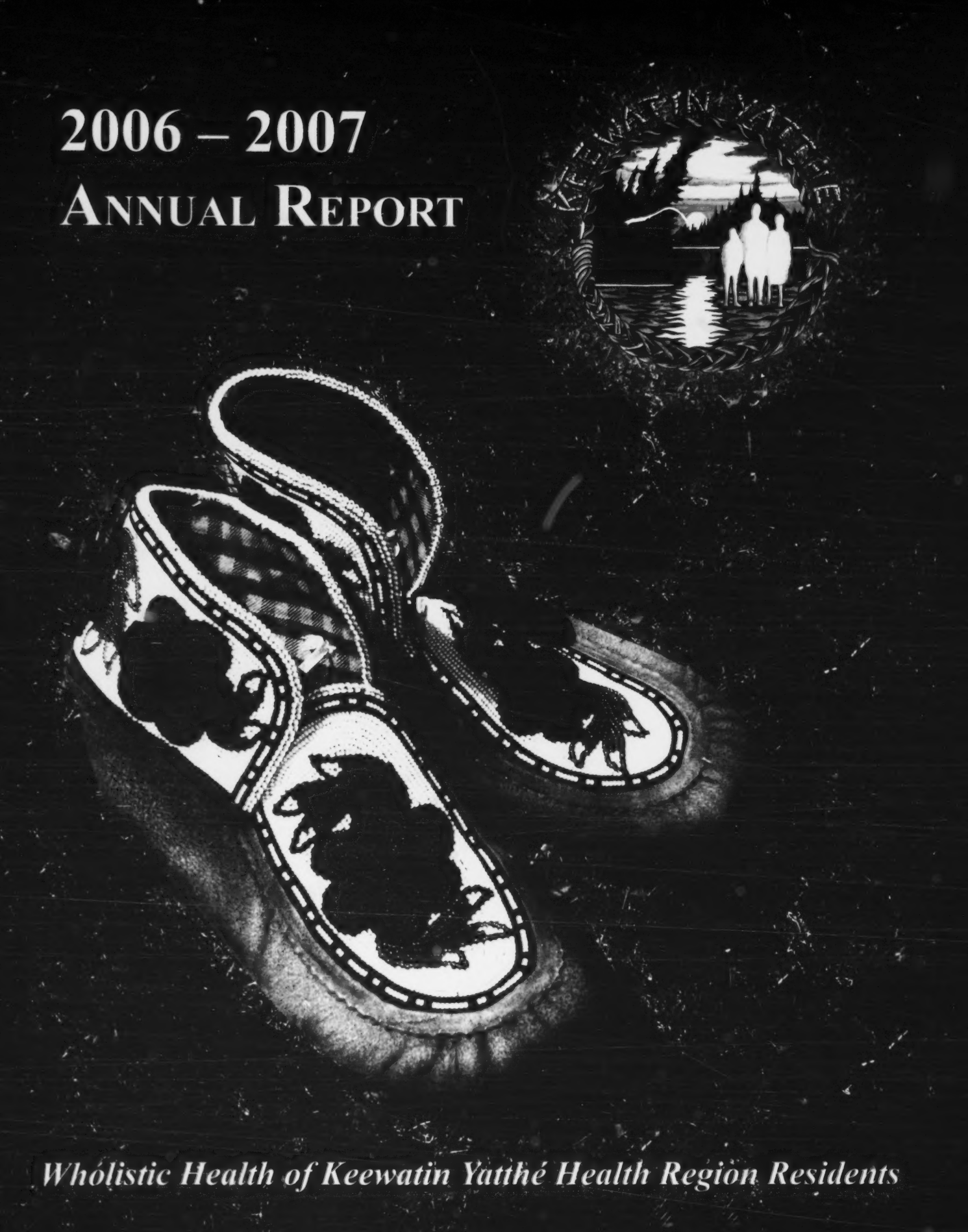
2006 – 2007 Annual Report



Wholistic Health of Keewatin Yatthé Health Region Residents

2008-05104/

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The following report is also available on-line at: **www.kyrha.ca**

LETTER OF TRANSMITTAL

To: The Honourable Len Taylor and The Honourable Graham Addley
Minister of Health Minister of Healthy Living Services

Dear Minister Taylor and Minister Addley,

The Keewatin Yatthé Regional Health Authority is pleased to provide you and the residents of the health region with its 2006-07 annual report. This report provides the audited financial statements and outlines activities and accomplishments of the region for the year ended March 31, 2007.

Some of the highlights of the past year are: the continued progress in construction of the Integrated Services Facility in Ile a la Crosse which is projected for completion in August 2007; the RHA's attainment of Accreditation status with report in February 2007; the Premier's Project Hope initiative; and inclusion in the chronic disease management collaborative.

Our overall success is greatly attributed to the care and excellence shown by the staff of the Keewatin Yatthé Health Region. It has been a privilege for me to serve along side such dedicated staff committed to caring for and improving the health and well being of our region residents.

Respectfully submitted,

David Seright
Chairperson

KEEWATIN YATTHÉ REGIONAL HEALTH AUTHORITY

MESSAGE FROM THE CEO

As I reflect on the past year, I remember the significant challenges the region has faced and the amazing way the Board, Management, Staff, and the residents of the Keewatin Yatthé Health Region have been able to work together to meet each and every one of these challenges.

The 2006-07 Annual Report is an honest and sincere publication of the existing risks in our region, the challenges the Health Authority faces, and the accomplishments of our hard working, excellent staff who make up the Keewatin Yatthé Regional Health Authority.

The pneumonia outbreak in one of our major northern communities last September-October 2006, the intense preparations for the accreditation survey (which was also an opportunity to take ownership of the our recognized issues and resolutions), and the approaching completion of the new Ile a la Crosse Integrated Services Facility, are just some examples that provide evidence of people that have truly pulled together in order to accomplish objectives so that we were able to continue to make the progress that we have.

I want to take this opportunity to thank the Board, Management, and Staff of the KYRHA for their continued commitment to working to improve the health status of the region.

Keewatin Yatthé RHA also believes that it is through a collective effort that solid advancements can be made for the benefit of our northern residents. In this light, I would also like to extend my thanks and appreciation to the many partnerships that we have been able to develope over the years, and we look forward to further enhancement of these partnerships.

Sincerely,

Carol Gillis
Chief Executive Officer
Keewatin Yatthé Regional Health Authority

The Mission Statement:

Wholistic Health of Keewatin Yatthé Health Region Residents

This Mission statement was born not just from a few hours of discussions around the Board table. It came about after a comprehensive consultation process with communities and residents.

What is Wholistic Health?

Wholistic is an all encompassing concept, which incorporates the individual, family, community, region, and the world at large.

- Wholistic Health is a balance of physical, mental, emotional, and spiritual wellness.
- Wholistic Health is a belief that the health of a person is tied the health of the family and the health of the community and visa versa.
- Wholistic Health is being responsible for one's own health. By being responsible it strengthens your ability to make better health decisions for yourself, your family, and you can participate more fully in your community.
- Wholistic Health looks at the heart of the issue. It asks why is it that I, my family, my community are unhealthy?
- Wholistic Health is having to work together, using our strengths.

WHO WE ARE

Fundamental to the identity and functioning of the Keewatin Yatthé Regional Health Authority (KYRHA) is this premise: that humanity is accountable to the Creator for their actions and that spiritual development is contingent upon relationship between the individual and Creator.

Throughout the generations, the key to the survival and progress of this north western region – alongside spiritual accountability and development, has been the interdependence between family and between communities.

The **Saskatchewan Health** directed vision of **building a province of healthy people and healthy communities** has been an underlying element in the formation of our objectives.

KYRHA believes that adults are responsible for their own health, supported by their extended family and local communities, and is fervent in commitment to a community approach in the delivery of services. We continue to take leadership initiatives that assist individuals, families, and communities in developing the knowledge, skills, abilities, and resources to carry out this responsibility by implementing a population health promotion approach.

Our Health Region faces great challenges in the area of: human resource management (i.e. available work pool; sick time and overtime); existing health facility infrastructure; and occupational health and safety issues… all which further compound issues associated with recruitment and retention. The health status of community residents and their great expectations and demands on the delivery of service further impacts the issues.

Existing capital pressures tie in to the nature of the socio-economic conditions of the north. With hunting, trapping, and 'living off the land' as the general lifestyle up until just a few decades ago, the tax base has not been developed to support infrastructure development. Approximately one-third of the population is under the age of 15 and with an employment rate that is almost one-half of the employment rate of the rest of Saskatchewan. The Health Region is burdened in its struggle to fundraise required amounts needed to replace or maintain existing infrastructure. It is important to note that in spite of the lack of funds available, admirable volunteer work has been done and gracious donations have been made to illustrate that there exists a population in the North with a hope for the future and a desire for the improved well being of their fellow residents.

The provision of additional or new community-based programs is generally pioneering in nature, never having really existed in the region. As a result, additional challenges (both financial

and administrative) exist in its launching and functionality. Delivery of service covers significantly greater geographic distance than in the rest of Saskatchewan, mileage costs are higher, and time allocated to the task increases significantly as well, which ultimately leads to less service delivery.

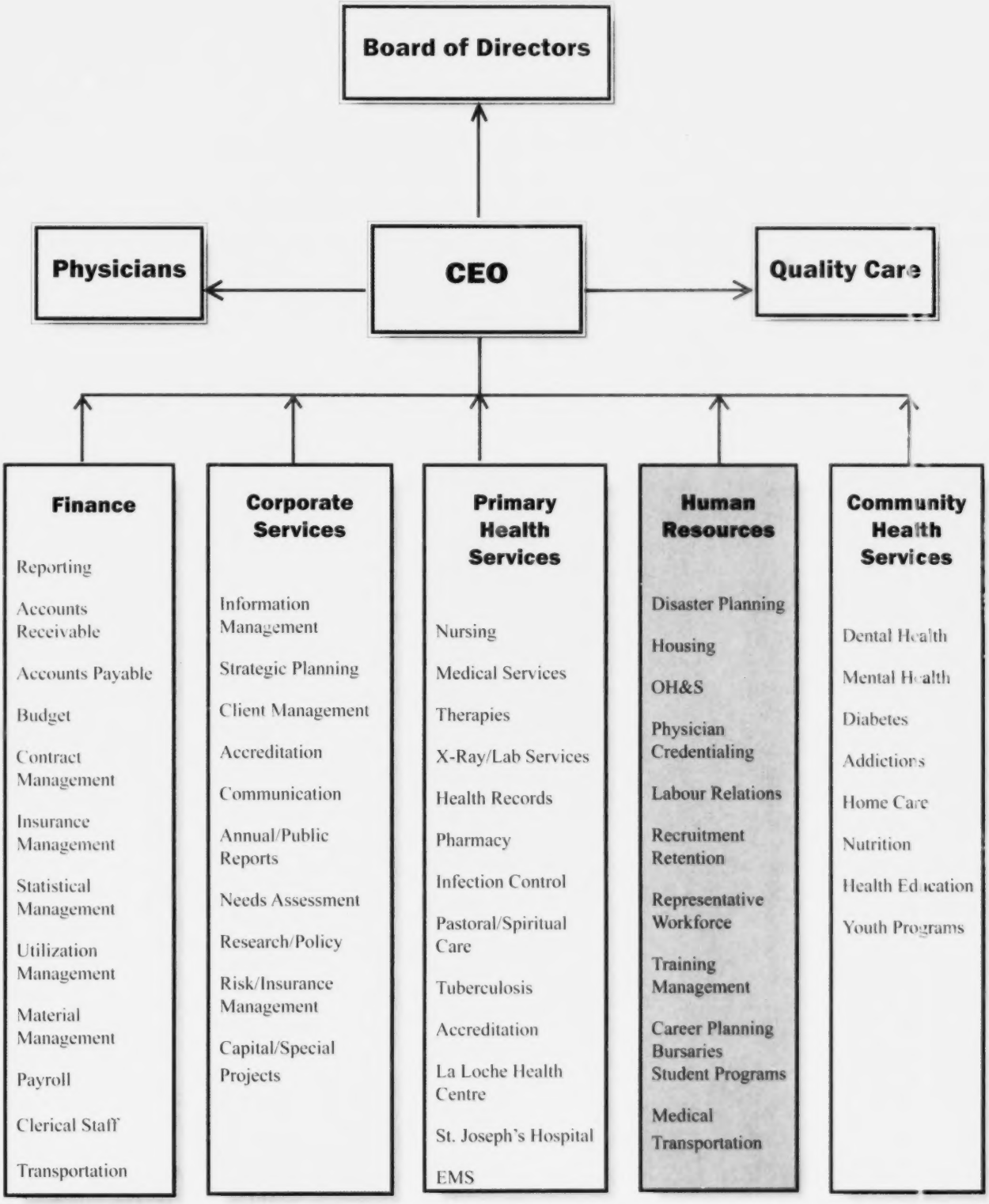
It would be difficult for the RHA to address the multitude of issues that impact health service delivery without the support of strong viable partnerships. Therefore partnerships are a critical component to making improvements. Our health is influenced by the interaction of many factors including socio-economic conditions, low employment, education, community and family supports, healthy childhood development, and personal health practices and coping skills. There are many groups, agencies, organizations, and levels of government as well as individuals that have an influence on health. Improvements in health can only come from these many sectors, including community leadership, working together.

An illustration of our efforts to work collaboratively with others to improve the health status of our northern residents is our commitment to the Northern Health Strategy. The Northern Health Strategy is comprised of Health Officials from both Provincial and Federal governments, First Nations organizations, Regional Health Authorities, and Northern Medical Services. The Northern Health Strategy has the potential to increase efficiencies and economies of scale for the member organizations through integration and collaboration to improve access and the quality of health services. The Strategy can provide the process and create the frameworks for long-term sustainability built upon existing structures. It is important to note that developing these arrangements for future sustainability of the health system requires time; the transition period is not a single event but a series of evolving steps.

The Health Region is responsible for planning, delivery, governance, management, quality, human resources, financial, information management, communications and issues management, capital and reporting and is accountable to the people it serves. The province mandates the region to provide service through the Regional Health Services Act.

The region is structured in a way that allows the region to operate as efficient as possible. The Board of Directors set the direction, which is carried out by the Chief Executive Officer and management.

Organizational Chart



KYRHA Sr. Management *(pictured l-r)*

Richard Petit,
Director of Corporate Services

Carol Gillis, *CEO*

Pat Malmgren,
Director of Primary Health Services

Wendy Ericson-Lemaigre,
Director of Human Resources

Elaine Malbeuf,
Director of Community Health Services

Zachery Solomon, *Director of Finance*

Changes and new additions not in the photo are: Mark Cook - Director of Finance, Gabrielle Fontaine - Quality of Care Coordinator.

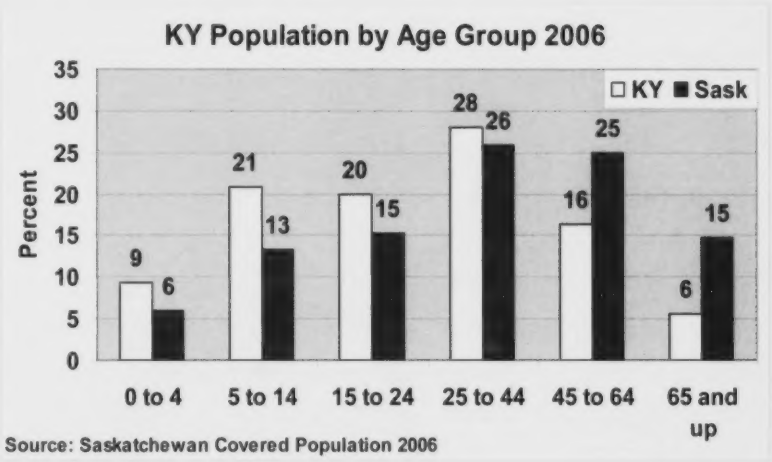
On January 29th, 2007, a retirement party was held for Denise Desjarlais, KYRHA Quality of Care Coordinator/Privacy Officer. Pictured above is Denise surrounded by some of the well-wishers that were able to attend. Back row (L-R): Dr. Britton, Darren Lewis, Clay Benaschak, Wendy Ericson-Lemaigre, Robert Daigneault, and Louis Roy. Middle row (L-R): Iris Clarke, Bernice Corrigal, Rebecca Ratt, Denise Desjarlais, Anna Corrigal, Shaylene Morin. Front row: Pat Malmgren and Carol Gillis.

Our Region

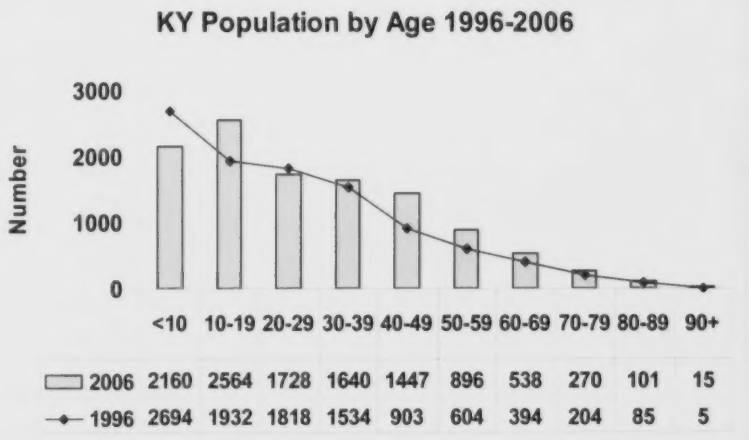
Key geographical, social and economic factors

Population by Age Group

• The Keewatin Yatthé (KY) Health Region continues to have a young, growing population. In 2006, KY had 30% of its population under 15 and only 6% aged 65 or older. Saskatchewan had only 19% under 15 but 15% were aged 65 or older. The KY population has increased by 11.7% in the past 10 years. The age groups with the greatest increase in numbers are the 10-19 and 40-60 age groups.

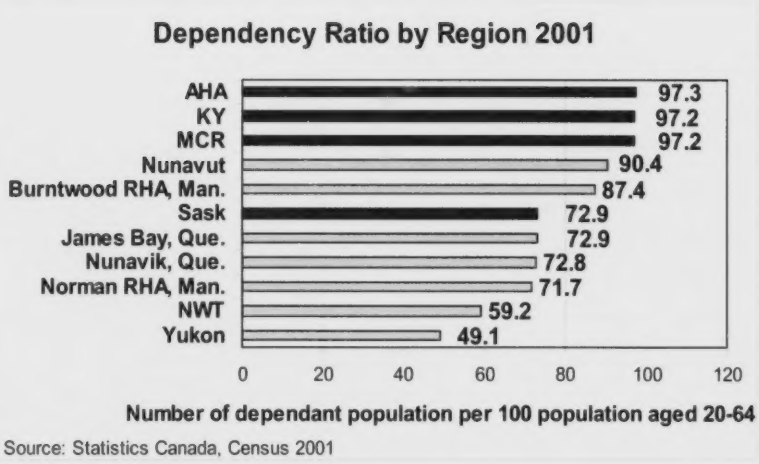


• The absolute population increase in each of these age groups has implications on health needs and health service requirements. KY along with Mamawetan Churchill River Health region and the Athabasca Health Authority have the highest 'dependency ratio' of all other health regions in Canada (from a May 2007 Statistics Canada report). This is a reflection of the number of youth under 20 and elders over 65 years of age compared to the middle aged groups.



Dependency Ratio

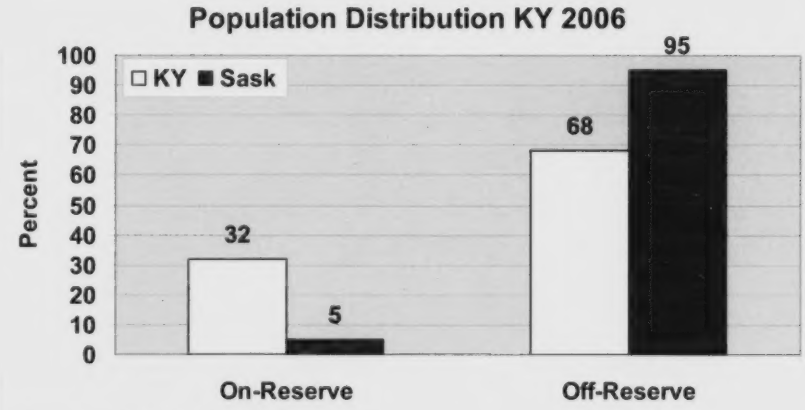
• Dependency ratios are economic indicators – regions with high dependency ratios indicate economically stressed areas.



Source: Statistics Canada, Census 2001

Population Distribution

In 2006, approximately one third of the residents lived on-reserve (32% on-reserve, 68% off-reserve). This is in marked contrast to the overall Saskatchewan population, where only 5% of the population live in reserve communities.



Source: Statistics Canada, 2006 Census

School Enrolment K-12

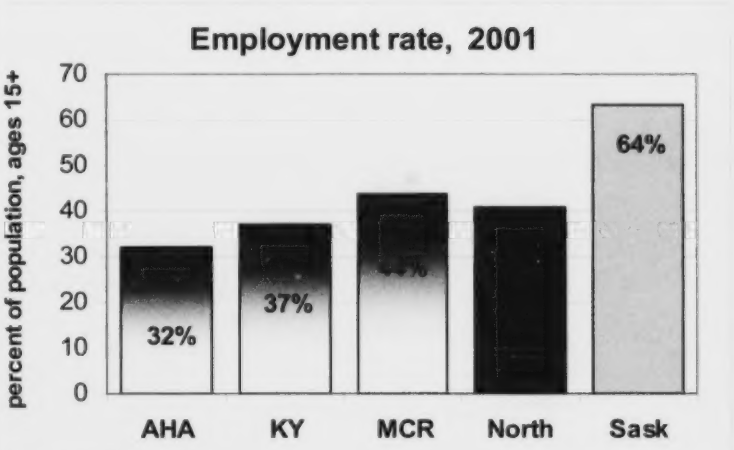
Enrolment in northern K-12 schools grew by 3% between 1998/9 and 2005/6. Most of the growth has been in middle years and secondary enrolments and in First Nations schools. Enrolments in northern provincial kindergarten and elementary grades decreased by 33% and 26% respectively. (Northern Saskatchewan Regional Training Needs Assessment Report 2006)

Non-medical determinants of health for the KY region

- 94.5 % of the KY population are Aboriginal, compared to 13.5% in Saskatchewan (Census 2001)

- An Aboriginal language was spoken in the homes of 50.7% of northern people in 2001, up from 47.6% in 1996, compared to 3 % of Saskatchewan people, up from 2.5% in 1996.

- Almost 50 % of the population are Métis people (Census 2001)



Source: 2001 Census

- The employment rate in KYHR was 37.2%, compared to 63.5% in Saskatchewan 2001.

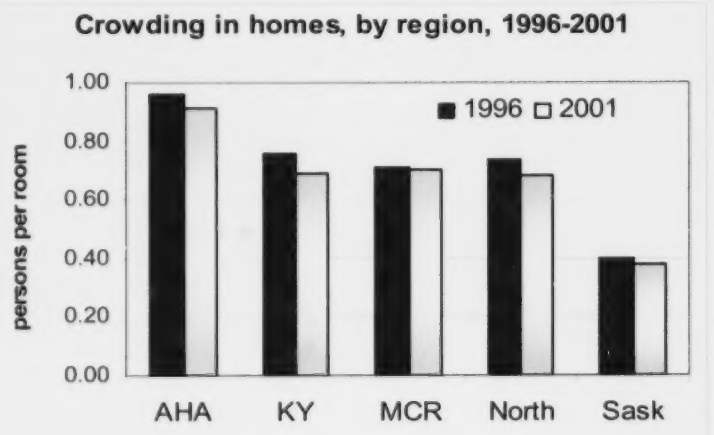
- In KY HR, 47.3% of children, compared to 19.2% in Saskatchewan, are in low income families. (2001 Census)

- In the KY HR, the average personal income for males ($17,754) and females ($15,244) was 56.7% and 74.4% of the average incomes for their Saskatchewan counterparts. (Census 2001)

Crowding in homes

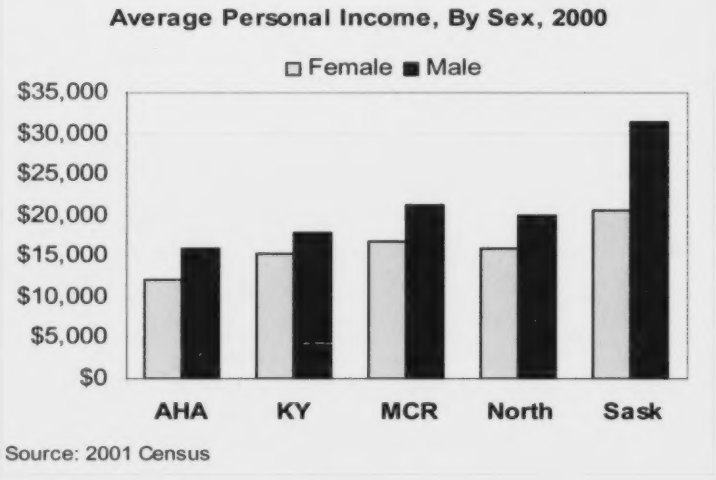
- Crowded housing contributes to transmission of communicable diseases. The average number of people per room decreased between the 1996 and 2001 Census years, but still remains nearly double the average for all of Saskatchewan.

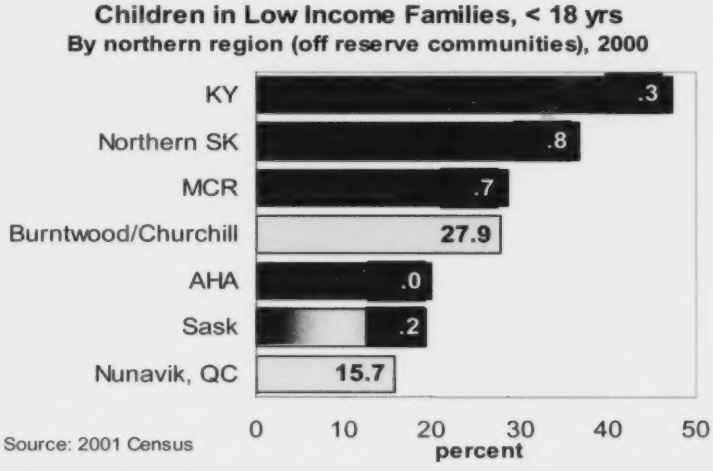
The indicators for the non-medical determinants of health for the KY region indicate significant challenges.



Source: Census 1996 and 2001

The high dependency rate as well as the unemployment rate are indicators of economic stress, with implications on childhood poverty levels as well as overall health. The growing population puts additional stresses on the health services in the region. With the growth in the adolescent and middle-age groups will impact numbers of individuals with diabetes, heart disease and cancer as well as conditions common in adolescents and young adults including injuries, pregnancies, and sexually transmitted infections.





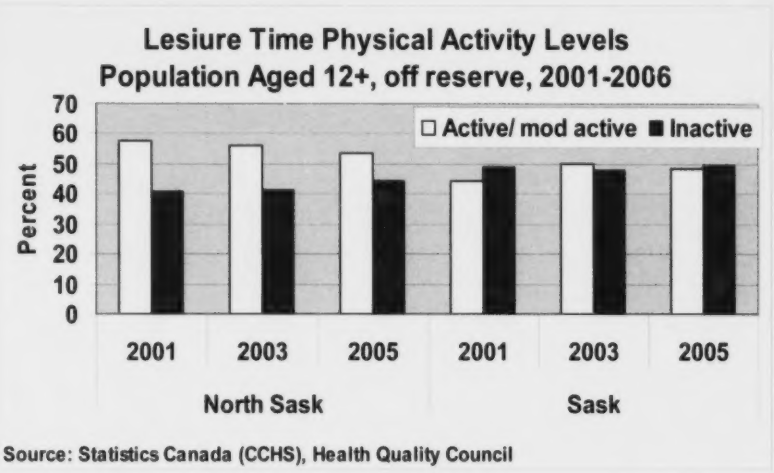
Overweight and obese people

People who are classified as overweight have a Body Mass Index of 25.0-29.0, while those who are obese have a BMI of 30.0 or greater. Overweight and obese people are at higher risk to develop diseases such as type-2 diabetes, high blood pressure, heart disease, some cancers, gallbladder disease, and others. In 2005, 33.9% and 24.2% of northern Saskatchewan residents reported being either overweight or obese, respectively. The disparity between northern Saskatchewan rates and provincial rates has increased from 2001-2005 which emphasizes the important continuing need for health promotion, intersectoral initiatives.

Physical activity during leisure time

In comparison to other Saskatchewan health regions, the northern health authorities had the highest percentage of residents who reported participating in active or moderately active levels of physical activity during leisure time in 2005. Similarly, the northern health regions

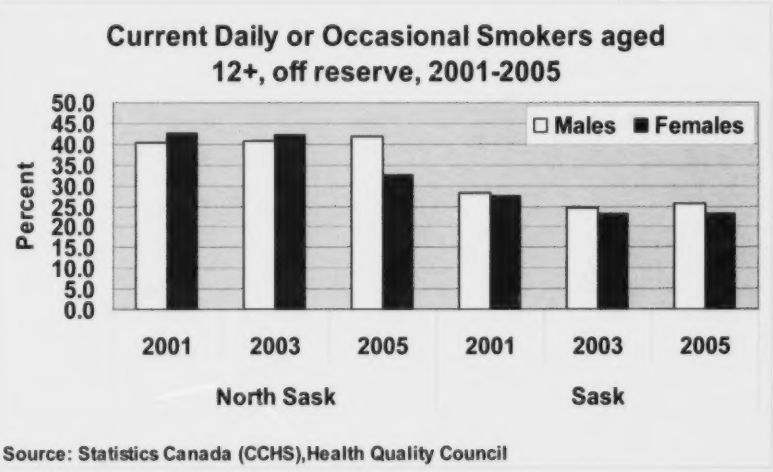
also had the lowest percentage of residents who reported inactivity levels However, the percentage of northern residents reporting active or moderately active physical activity levels has been decreasing slightly since 2001 (57.4% to 53.4%), while those reporting inactivity has been increasing slightly during the same time period (40.5% to 44.1%).



Source: Statistics Canada (CCHS), Health Quality Council

Smoking rates

Smoking rates in northern Saskatchewan off-reserve communities remain substantially higher than provincial rates though there appears to be some improvement in female rates in 2005. The percent of off-reserve northern males aged 12+ that report current daily or occasionally smoking has remained relatively stable since 2001 (40.2, 40.7, 41.8%). On the other hand, the percent of females reporting to smoke has shown a 9.7% decrease in 2005 compared to 2003, going from 42.0 to 32.3%. Northern rates for both males and females remain substantially higher then provincial rates in 2005 (25.6% in males and 22.9% in females).

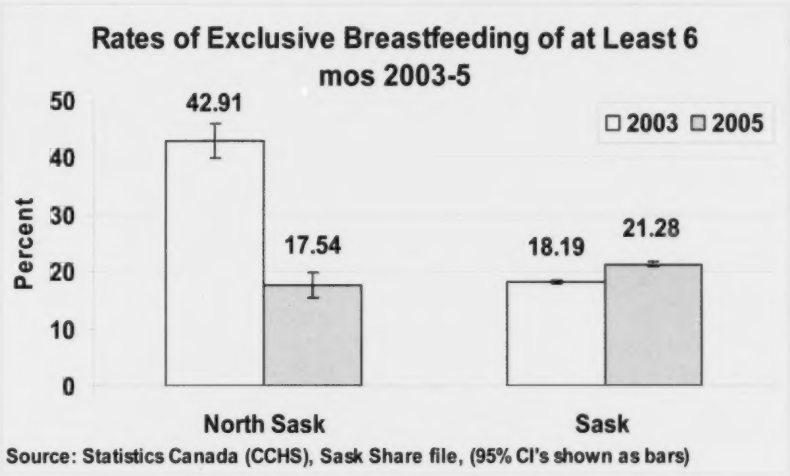


Source: Statistics Canada (CCHS),Health Quality Council

Breastfeeding

The percentage of northern mothers that breastfed exclusively to at least 6 months decreased substantially between 2003 (42.91%) and 2005 (17.54%). During the same time period the provincial rate increased slightly from 18.19% to 21.28%. Though small numbers of people

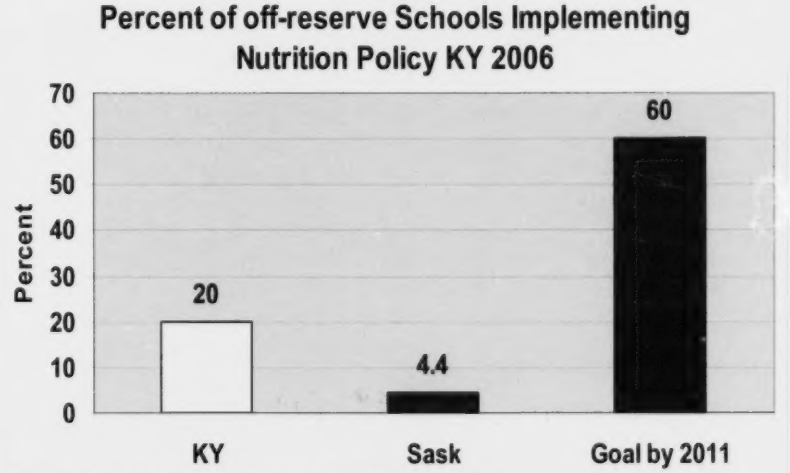
involved in the northern component of the CCHS may have some influence on this northern variation, confidence intervals suggest that this change is a significant reduction in breastfeeding rates in northern Saskatchewan. Though small numbers of people involved in the northern component of the CCHS may have some influence on the northern variation, confidence intervals suggest that this change is a significant reduction in breastfeeding rates in northern Saskatchewan. Further investigation will be required to suggest an explanation for the decrease.



Source: Statistics Canada (CCHS), Sask Share file, (95% CI's shown as bars)

School nutrition policies

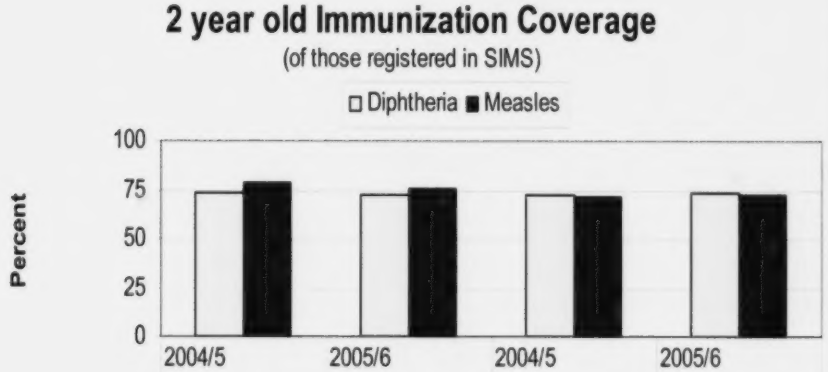
Schools that have a written nutrition policy have taken the important first step of implementing nutrition policies, which in turn can be an important component of a healthy school environment that promotes healthy lifestyles for its students. The provincial goal is for 60% of all schools in the province having written school policies by the year 2011. It appears that KY has taken a good step forward. Of all the health regions, KY had the second highest proportion of schools that are implementing a nutrition policy (20%).



Source: Sask Health, Health promotion lead committee

Immunization Management

The percentage of KY clients registered in the Saskatchewan Immunization Management System (SIMS) that received the recommended immunizations slightly decreased between 2004/5 and 2005/6, from 73.9% to 72.7% for diphtheria and 78.4% to 75.8% for measles. On the other hand, small increases were noted at the provincial level, going from 72.9% to 73.5% for diphtheria and 71.2% to 72.5% for measles, both of which remain similar to KY rates.

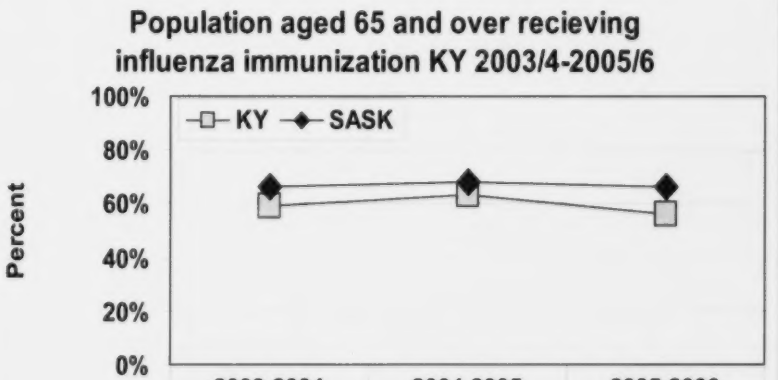


	KY 2004/5	KY 2005/6	Sask 2004/5	Sask 2005/6
Diphtheria	73.9	72.7	72.9	73.5
Measles	78.4	75.8	71.2	72.5

Source: Sask Health (SIMS),
Prepared by Population Health Unit, May 18, 2007

Population aged 65 and over receiving influenza immunization

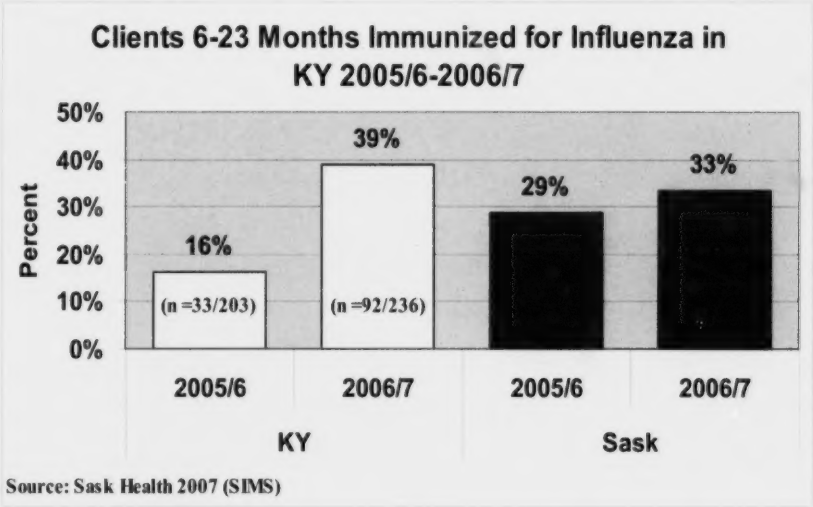
The percentage of the KY population aged 65 and over that received the influenza immunization decreased between 2004/5 and 2005/6, from 63% to 56%. During that same time, Saskatchewan rates decreased from 68% to 66%, but remained higher than KY rates. Challenges of recruitment and retention of public health nursing staff continue.



	2003-2004	2004-2005	2005-2006
KY	59%	63%	56%
SASK	66%	68%	66%

Population aged 6 to 23 months that received influenza immunization

The percentage of KY clients aged 6 to 23 months that received an influenza immunization increased 2.4 times from 16% in 2005/6 to 39% in 2006/7. At the same time the Saskatchewan coverage rate increased from 29% to 33%, which is slightly lower than the KY rate. The higher rate of immunization in KY may partially be a result of the mass immunization for childhood immunization we had in one of the larger communities in dealing with a community-acquired pneumonia outbreak. The goal for coverage is significantly higher. This may also be a reflection of the challenges to recruiting and maintaining public health nurses in many northern communities and reveals the need for greater public and health professional education on the benefits of childhood influenza vaccination especially in areas of greater risk of complications from influenza such as regions with higher community-associated MRSA (Methicillin-resistant Staphylococcus aureus) rates. There has been reports of increased risk of severe MRSA pneumonias following childhood influenza.

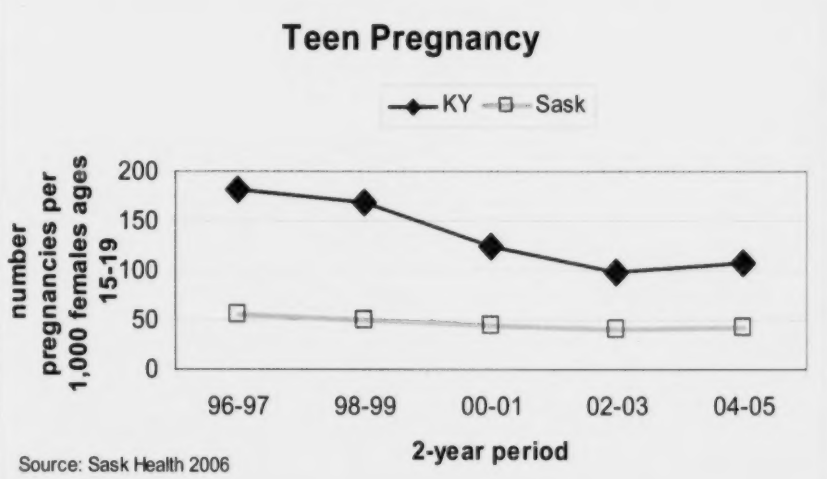


Source: Sask Health 2007 (SIMS)

Teen pregnancy

There has been a gradual reduction in the teen pregnancy rate over the past decade with the rate in 2004-5 being about 60% of the rate in 1996-97.

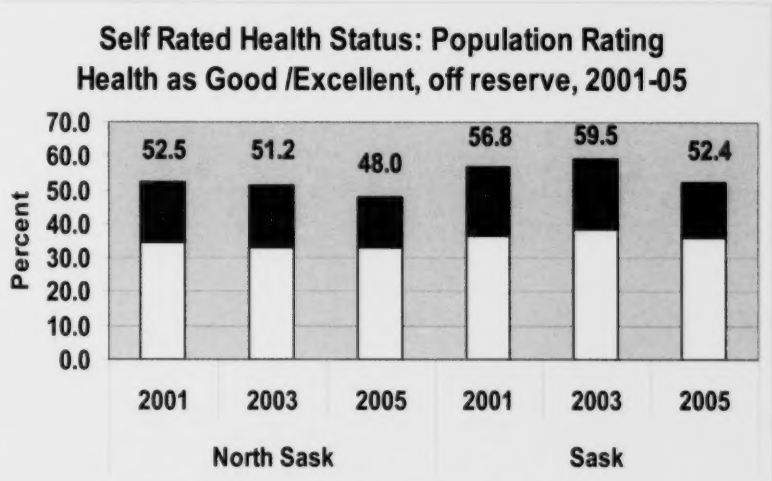
The teen pregnancy rate in KYHR, though decreasing, continues to be about 2.5 times the provincial rate.



Source: Sask Health 2006

Self Rated Health Status

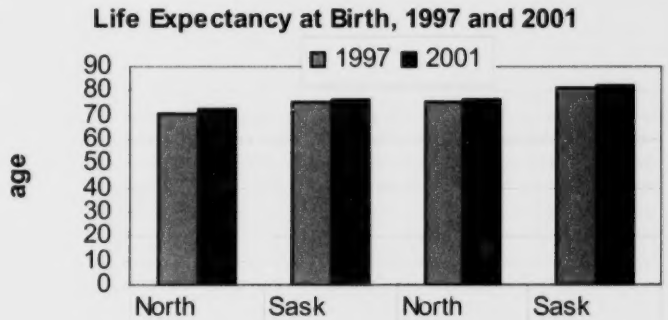
Self rated health status is good indicator of overall health as it corresponds with the individual's personal meaning of health. Thus, this indicator can capture components of health, such as early stages of disease, disease severity, aspects of positive health status, physiological and psychological reserves and social and mental function, which other measures can not. Since 2003, Northern residents' self rated health status has remained relatively stable in the very good category (32.9 in 2003 and 32.83% in 2005) but has decreased in the excellent category (18.4% in 2003 and 15.12% in 2005). The province has seen decreases in both the very good (38.6% in 2003 and 35.74% in 2005) and excellent categories (20.8% in 2003 and 16.6% in 2005); however both categories of self rated health status remain higher at the provincial level than in the northern health authorities.



Source: Statistics Canada (CCHS), Health Quality Council

Life expectancy (at birth and at age 65 years)

The life expectancy at birth in the three northern health regions increased 0.5 years among females to 76.1 years and 1.7 years among males (to 72.1 years) from 1997 to 2001. Although the life expectancy for northern residents remains significantly lower than for all of Saskatchewan, the gap in life expectancy at birth is closing with only a 0.4 year gain among females (to 81.8 years) and 0.6 year gain among males (to 76.2 years) across Saskatchewan in the same period.

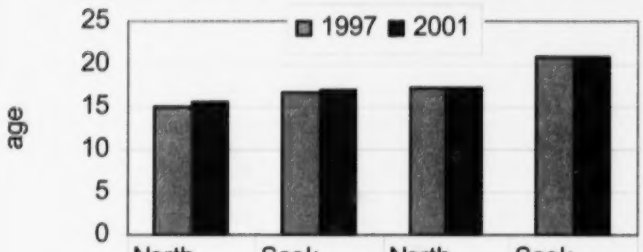


	Males		Females	
1997	70.4	75.6	75.6	81.4
2001	72.1	76.2	76.1	81.8

Source: Statistics Canada, May 2005

The life expectancy among those who reach age 65 in the three northern health regions decreased from 1997 to 2001 by 0.1 year among females (to 17.2 years of life or 82.2 years of age) and 0.5 years among males (to 15.6 years of life or 80.6 years of age). For all of Saskatchewan, females at age 65 in 2001 could expect to live 0.2 years longer than in 1995 and males could expect to live 0.3 years longer.

Life Expectancy at Age 65, 1997 and 2001



	Males		Females	
1997	15.1	16.6	17.3	20.7
2001	15.6	16.9	17.2	20.9

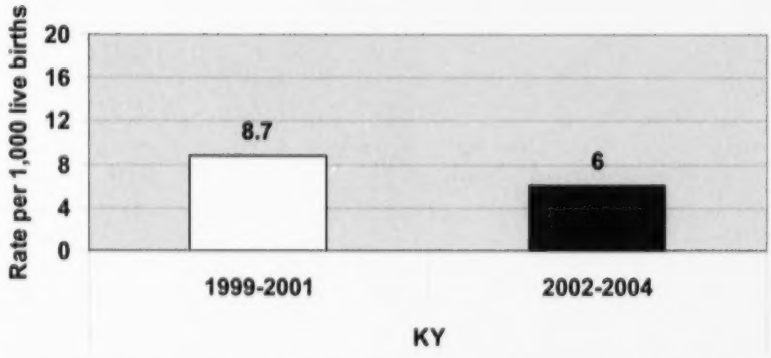
Source: Statistics Canada, May 2005

Northern Saskatchewan residents have the lowest life expectancy in the province at birth and at age 65, reflecting their overall health status in comparison to their southern counterparts, as well as the influence of health determinants such as the proportion of the population living in poverty. Higher rates of infant mortality and premature deaths from injuries seen in the north could also be a contributing factor to the lower life expectancies of northern residents.

Infant Deaths

There were fewer than 5 infant deaths in the KY Health Region in the three year period of 2002 to 2004 compared to 6 in 1999-2001. With small numbers, there can be wide fluctuations in rates from one time period to another. This represents more than a 30 percent decrease in the infant mortality rate (IMR) from 8.7 infant deaths per 1,000 live births in 1999-2001 to 6.0 in 2002-4. Preliminary data for 2005 indicate a rate of 5.8 deaths per 1,000 live births. In comparison, the IMR for Saskatchewan dropped from 6.2 to 5.9 infant deaths per 1000 live births from 1999-2001 to 2002-2004.

Infant Death Rates KY

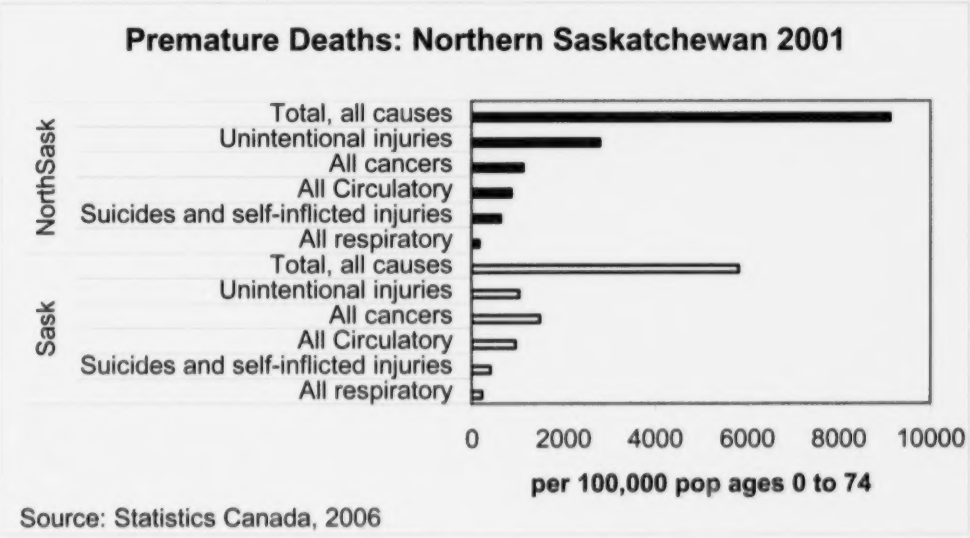


Source: Sask Health Vital Statistics, Perfomance management summary (preliminary data)

The infant mortality rate is a measure of child health and also of the well-being of a society. It reflects the level of mortality, health status, and health care of a population, and the effectiveness of preventive care and the attention paid to maternal and child health. Increased funding and efforts aimed at reducing infant mortality in northern regions over the past two years have been focused on improving prenatal nutrition and prenatal care, as well as reproductive health education.

Premature Deaths (Potential Years of Life Lost)

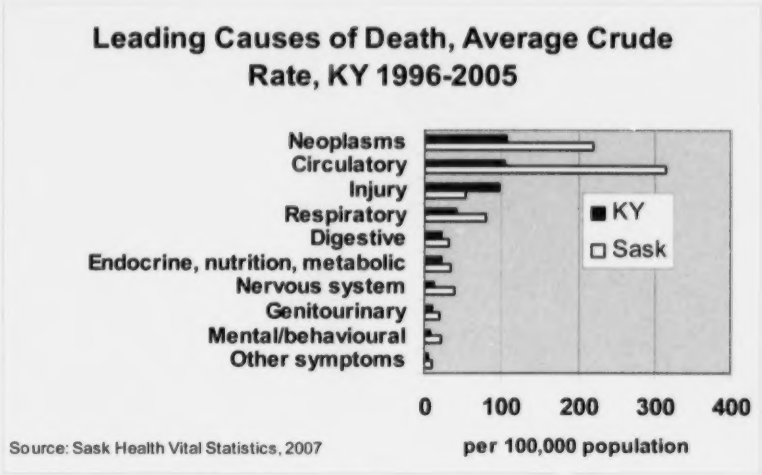
The rate of premature deaths in northern Saskatchewan is significantly higher than in other parts of Saskatchewan. The cause of death that has the most impact on this difference is unintentional injuries (2.7 times the rate in the north compared to the provincial rate).



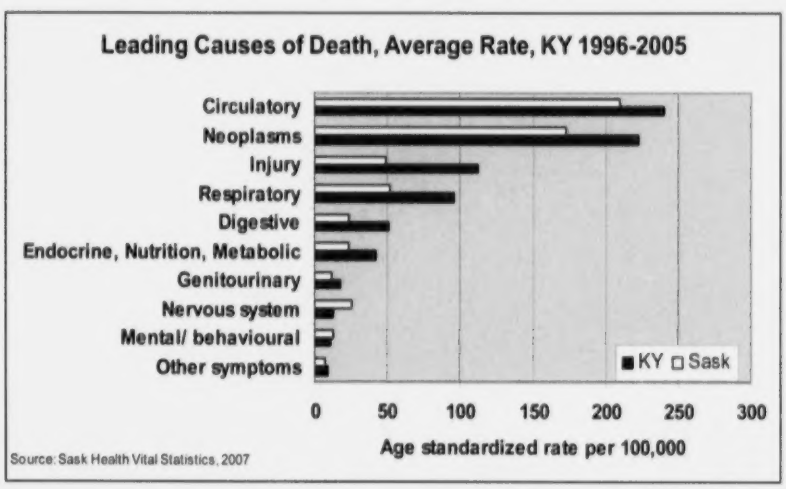
Source: Statistics Canada, 2006

Leading Causes of Death

The leading causes of death in KY (crude rate) between 1996 and 2005 were neoplasms, circulatory diseases, and injuries, In contrast, the leading causes of death in Saskatchewan, over the same time period, were circulatory, neoplasm and respiratory diseases. This difference is not surprising as the population in KYHR is much younger (where injuries are more dominant), with less population in the older age groups (where the chronic conditions such respiratory diseases are more common).

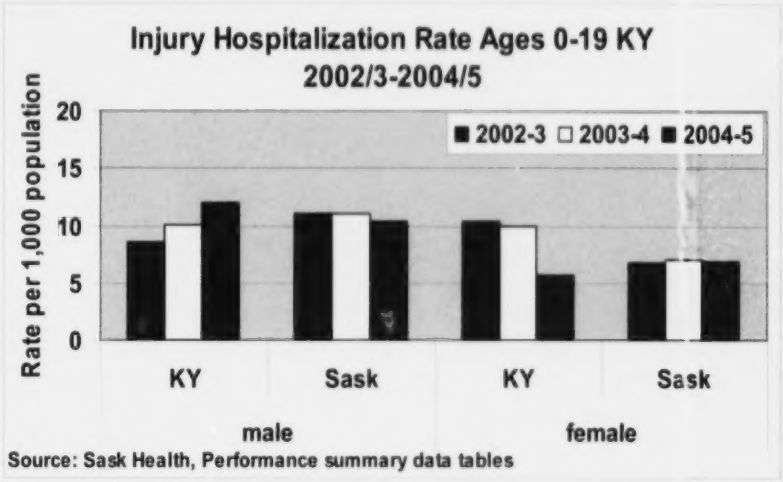


As the middle-aged and elderly (who have higher rates of chronic diseases) make up a smaller proportion of the northern population, age-sex adjustments have to be made in order to allow for provincial comparisons. After these adjustments are made, circulatory diseases, neoplasms injuries and respiratory diseases remain the 4 leading causes of death in KY; however these rates are now higher than the provincial rates. Age-standardization allows for a more accurate comparison of health risks between population groups.



Injury hospitalization: Ages 0-19

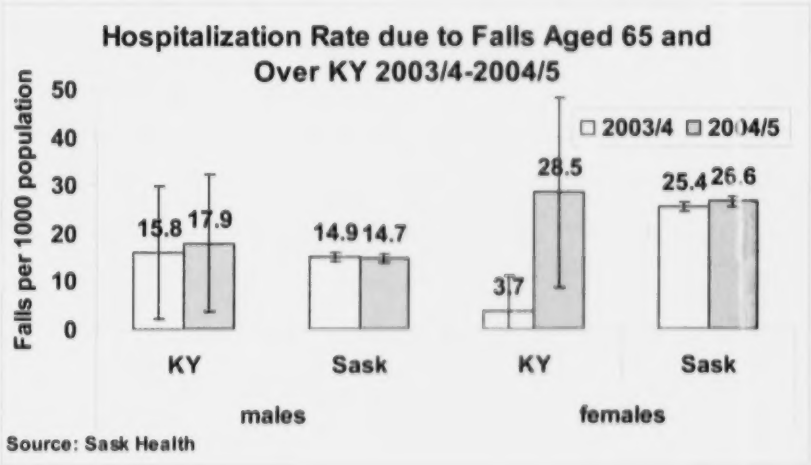
The injury hospitalization rate for children and youth aged 0-19, has decreased from 9.9 cases per 1,000 population in 2003/4 to 5.7 cases in 2004/5 for females in KY. The KY rate is now slightly lower than the provincial rate (6.9), which remained relatively stable from 2003/4 (7.1). In males, KY seen a slight increase in the rate from 2003/4 (10.1) to 2004/5 (12.0). A small decrease was seen at the provincial level in males where the rate decreased from 11.1 cases in 2003/4 to 10.4 cases in 2004/5. However, caution should be taken when comparing the northern rates, as the relatively small numbers of injury-related hospitalizations can lead to wide fluctuations in year to year rates, as well as lower confidence in the values.



Source: Sask Health, Performance summary data tables

Hospitalization rate due to falls

The hospitalization rate due to falls in the KY population aged 65 and over, rose in males from 15.8 hospitalizations due to falls per 1000 population in 2003/4 to 17.9 hospitalizations in 2004/5. In KY females, the rate increased from 3.7 hospitalizations to 28.5 hospitalizations, over the same time period. At the provincial level, the male rate decreased from 14.9 to 14.7, whereas the female rate rose from 25.4 to 26.6. However, caution should be taken when comparing the northern rates, as the relatively small numbers of hospitalizations due to falls



Source: Sask Health

can lead to wide fluctuations in year to year rates, as well as lower confidence in the values (as seen by the very large 95% confidence intervals). This may explain the large fluctuation between 2003/4 and 2004/5 in the KY population.

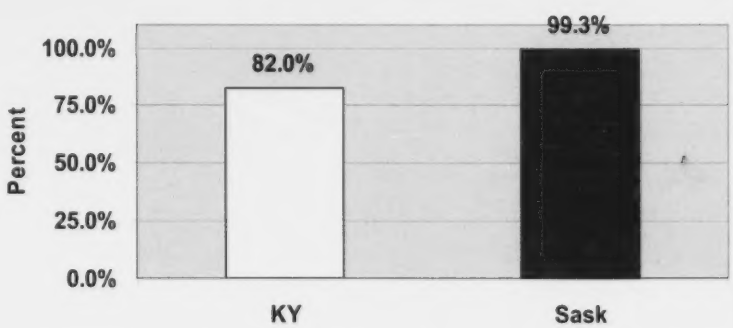
Coverage for Public Health Inspection

The percentage of licensed or regulated facilities that were inspected in the North increased substantially in almost all areas between 2005/6 and 2006/7. The only area to decrease was swimming pools (62-45%). As there are only a small number of swimming pools in the North, small changes in inspection can lead to large fluctuations in inspection rates from year to year. The biggest differences were noticed in food processing, lodging, and public water supplies, which increased by 3.4, 2.5 and 2.4 times, respectively. The reason for these large increases in inspection rates may be explained, in large part, due to the recruitment and retention initiatives in public health inspector field staff.

Source: Public Health Inspector Information System, Sask Health

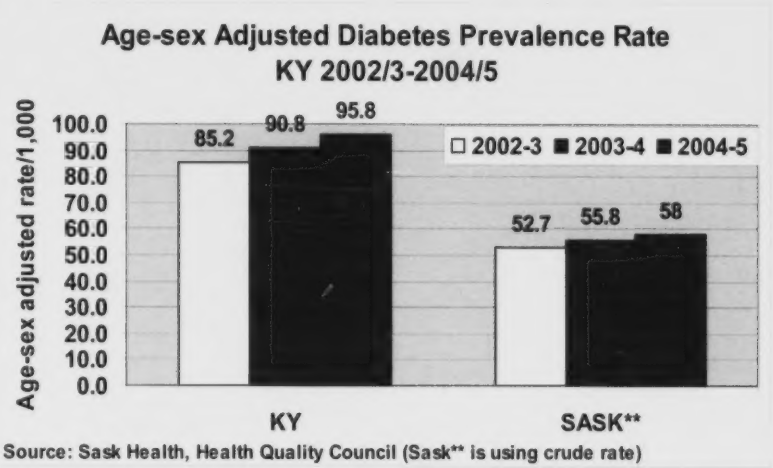
Percent of Ambulance Calls with at an EMT

One of the key factors in emergency situations is the presence of expert responders. In 2005/6 KY received 907 ambulance calls and of those calls, 82% of them were answered by individuals with at least emergency medical technician (EMT) training. Compared with the other health regions in the province, this rate was the lowest.



Diabetes Prevalence Rate

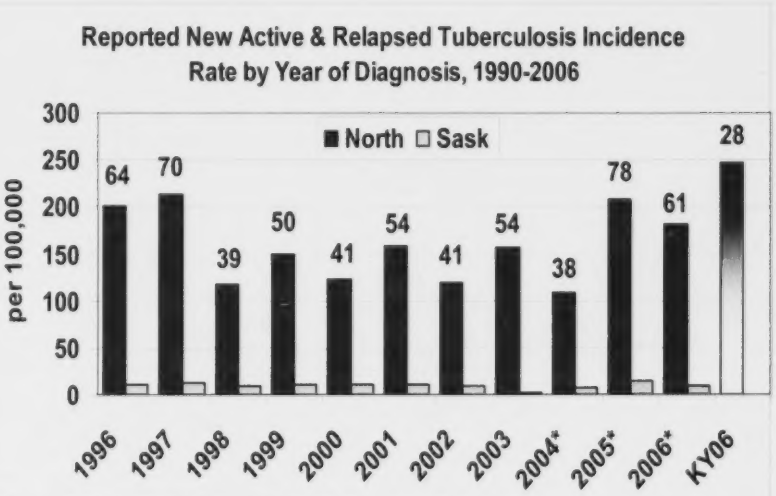
The proportion of people living in KY with diabetes (prevalence rate) increased by 2.7 cases per 1,000 population in 2004/5 from 2003/4 (50.2 to 52.9). As the middle-aged and elderly (who have higher rates of diabetes) make up a smaller proportion of the northern population, age-sex adjustments have to be made in order to allow for provincial comparisons. The age-sex adjusted diabetes prevalence rate in KY has been steadily increasing since 2002/3, up by 10.6 cases per 1,000 population in 2004/5. The age-sex adjusted diabetes prevalence rate in KY is over 60% higher than the provincial rate.



Source: Sask Health, Health Quality Council (Sask** is using crude rate)

Tuberculosis continues

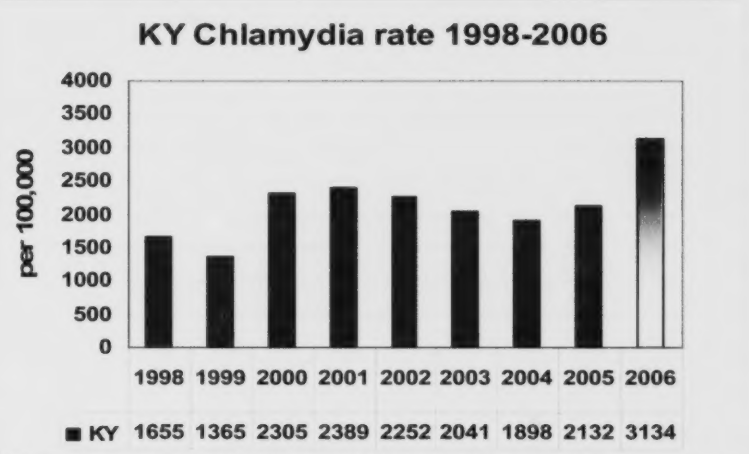
In 2006 the North had a decrease in its TB rate from 208.5 cases in 2005 to 180.8 cases in 2006. This remains 19.0 times higher than the provincial rate. Of the 61 northern cases of new active and relapsed TB cases, 28 cases. The 2006 KY rate of 246.5 cases per 100,000 population also remains substantially higher than the 2006 provincial rate. The TB incidence rate in KY is 26 times the overall Saskatchewan rate. About 93% of the new and relapsed cases of TB in KY for 2006 were living off-reserve.



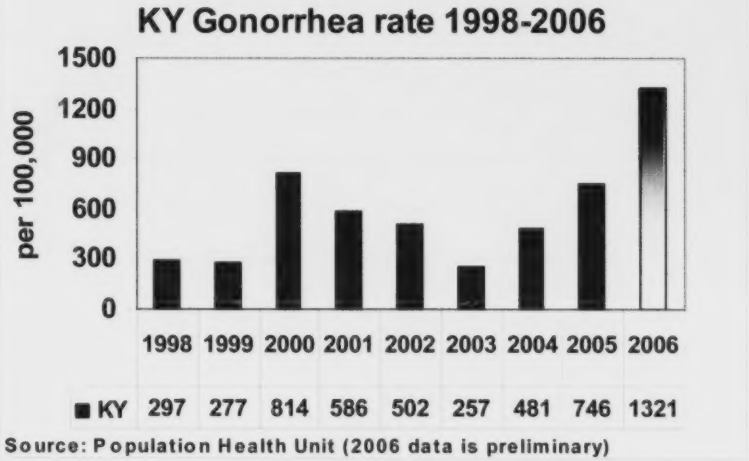
Source: Sask Health, TB Control and Health Canada *preliminary data;

Sexually Transmitted Infections

The rate of chlamydia in KY appears to have risen in 2006 to its highest level, 3134 cases per 100, 000, since 1998. Compared to 2005, KY had 1.5 times the total number of cases of chlamydia in 2006 (356 in 2006 compared to 243 in 2005). The rate of gonorrhea in KY appears to have risen 1.8 times from 746 cases per 100,000 population in 2005, to 1321 cases in 2006. The total number of gonorrhea cases in KY increased from 85 in 2005 to 150 in 2006. Some of this increase may reflect increases seen in other parts of Saskatchewan and Canada.



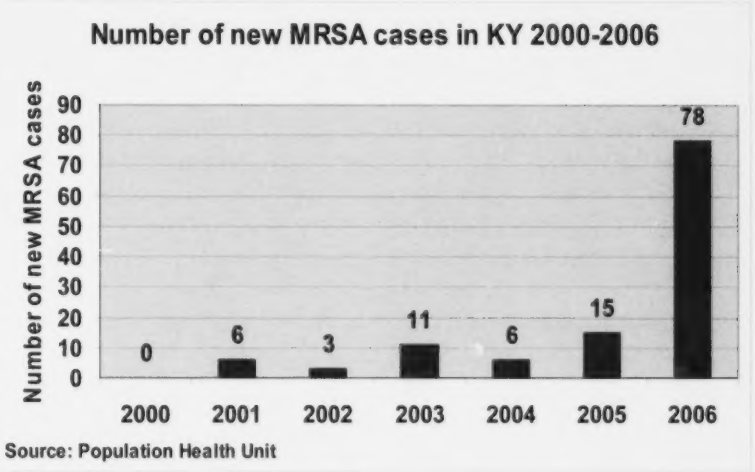
Source: Population Health Unit (2006 data is preliminary)



Source: Population Health Unit (2006 data is preliminary)

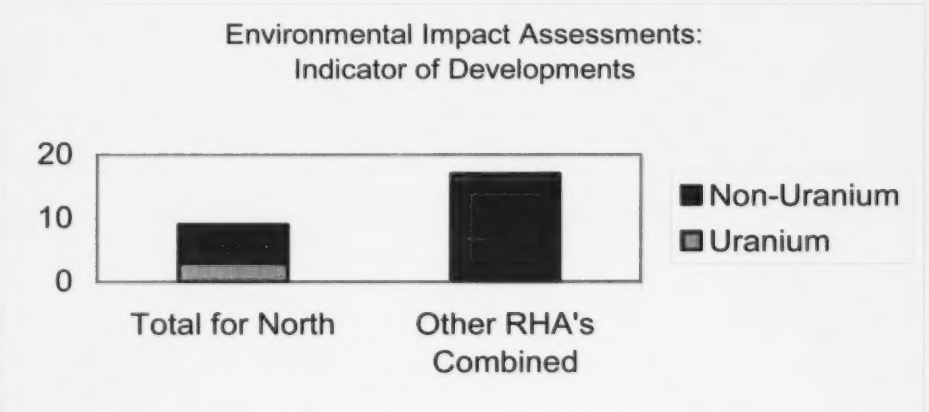
MRSA Cases in 2000-2006

Methicillin-resistant Staphylococcus Aureus (MRSA), a Staphylococcus bacterium resistant to common antibiotics including methicillin, has been known to occur in hospital settings. More recently, it has been shown to occur in the community setting, and is known as community-acquired MRSA. In the north, the community-acquired MRSA predominates and has been on the rise in KY since 2000. The number of new MRSA reached its highest total in 2006 with 78 new cases. MRSA can result in a variety of skin and soft-tissue infections ranging from boils to severe bone or muscle infections and can also result in severe pneumonias. Increased attention to community-based hygiene conditions and education as well as infection control strategies, are required.



Environmental Impact Assessments

There has been significant expansion in the mineral, uranium and oil exploration in the KYHR. This has significant potential ramifications as it relates to population changes and economic development but also has potentially serious ramifications as it relates to social health concerns. As an indicator of economic development, our Population Health Unit was involved with 9 Environmental Impact Assessments across the north this past year compared to 17 done in the 10 other health regions combined.



2006 - 2007 Results at a Glance

The goals and objectives of the health region are consistent with the broad provincial goals for the health system as per Saskatchewan Health Care Provincial Plan.

Goal 1 – Improved Access to Quality Health Care

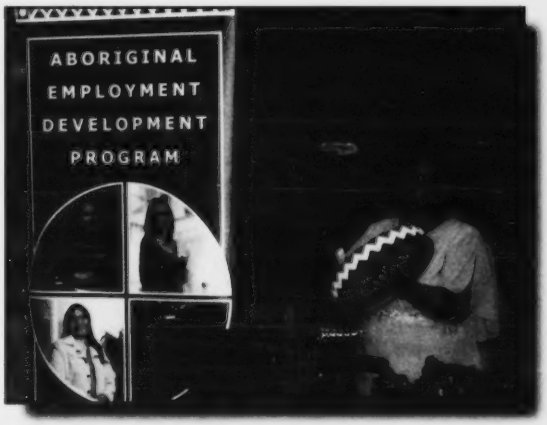
- Ensure accessible health services for all region residents
- Participation in the Canadian Council on Health Services Accreditation process.
- Increased hours at Buffalo Narrows clinic on a trial basis in order to increase access to primary care nursing especially for clients that work during the day.
- Team facilitation
- La Loche – working to increase physician access in the clinic
- Chronic Disease Collaborative
  A team initiative started in Ile a la Crosse in collaboration with the Saskatchewan Health Quality Council. Consists of tracking clients with diabetes, doing chart audits, monitoring chart/record consistency toward improving client care and creating a set of guidelines for client care.

Goal 2 – Effective Health Promotion and Disease Prevention

- Ongoing participation in the Northern Healthy Communities Partnership to support healthier places to live, work and play.
- Promotion of regional initiatives to support healthy lifestyles.
- Develop linkages/networks to support healing and healthy lifestyles.
- Increased hand washing campaign (Infection Control) for the public in all communities within the region.
- In house production of the Keewatin Yatthé Newsletter for staff and region residents to promote and support health awareness, promotion, and education.

Goal 3 - Retain, Recruit and Train Health Providers

- Participation in the Canadian Council on Health Services Accreditation process.
- Participation in the Provincial Recruitment Agency Project.
- Attendance at Career Fairs within the region in attempt to generate interest in health careers for students in the region.
- 13 students from the Health Region supported by Regional bursary program 10 Registered Nurses 3 Licensed Practical Nurses.
- Provided summer student employment in various health positions for students in attendance in health related education.
- Recruitment of 3 General Duty Nurses, two Combined Laboratory X-Ray Technicians. Realization of benefits of previously recruited foreign nurses to the region.
- Annual staff recognition ceremonies held in 2 locations.
- Provided Respectful Workplace Information Sessions, with La Loche as a pilot site for Provincial initiative.
- Provide training to Management staff in Man agement Competencies and Labour Relations training offered by SAHO.
- Primary Care Paramedic training partnership with Northlands College/SIAST.
- Physiotherapy Assistant Training – Partnership.
- Clinical Practicum of Three RN students.
- Practicum placement of Nutrition/Dietitian Student.



Goal 4 - A Sustainable, Efficient, Accountable, and Quality Health System

- Recieved Accreditation with Reports.
- Enhanced Health Information Management through electronic systems (i.e. Procura, IPFE, and WINCIS).
- Enhanced internal and external communications.
- Continued partnerships with agencies such as Kids First North, CPNP, Provincial TB Program, SGI, and regional community networks.
- Improvements in overtime and sicktime trends.

PERFORMANCE RESULTS

Goal 1 – Improved Access to Quality Health Care

Primary Health Services

- Develop/maintain facilities and services to meet the goal of reasonable access.
- Promote/develop Primary Health Care Services as per Saskatchewan Action Plan Guidelines.
- Participation with Chronic Disease Management Collaborative in Ile a la Crosse with expansion to Buffalo Narrows and Beauval in 2006-2007.
- Assessment of traffic flow to determine peak patient periods in primary health sites to increase access.
- Pilot project: the Primary Care Nursing clinic hours at the Buffalo Narrows Health Centre were expanded to provide greater access to health services. The new clinic hours for Monday – Friday included the lunch hour of 12 noon to 1PM and closed at 6 PM.
- Primary Care central team at the La Loche Health Centre working to improve clinic access for Physicians and Nurse Practitioners.
- Team building with different disciplines to enhance case management practices
- Electronic Tracking of client information to facilitate quality care

Barriers

- Staff/management buy in to primary health principles – team building efforts involving all service providers and management continues.
- Language barriers – English as a second language for the majority of clientele within the region is addressed by ensuring appropriate translation supports and consideration in communication methods (through greater use of images, style of literature, use of radio and cable television scroll messaging).
- Communication barriers – through community meetings and Practitioners consultations issues continued to be addressed.
- Increasing chronic disease rates – incorporation of a patient self-management group support program.

Community Health Services

- Implementation of a Community Mobile Treatment (pilot) Program in La Loche to enhance access to community based addictions treatment services/supports for youth.

- Developed a pilot Heart Health program to supports clients with coronary heart disease.
- Extend/Partner with First Nations communities to ensure access to Critical Incident Stress Management support for community residents.
- Continued involvement in the negotiations for a comprehensive Oral Health Strategy for residents of northern Saskatchewan.
- Social detoxification services via a Family Healing Unit for clients in La Loche.

Challenges

- Ongoing staff recruitment and retention issues impacting on program sustainability.
- Increasing chronic disease rates – incorporating a patient self-management group support program in the Fall of 2007.

Goal 2 – Effective Health Promotion and Disease Prevention

- Participation in an **Annual Youth Outdoor Wellness Conference** (focus is on the pro motion of healthy choices/lifestyles)
- Annual regional **Walking for Wellness Program**- promotes active and healthy life styles.
- Regional Diabetes Relay – in partnership with First Nations communities to enhance supports for diabetes prevention.
- Community Capacity Building – staff and community training in Applied Suicide Inter vention Training to enhance prevention efforts and to minimize potential years of lost life.
- Promotion of regional Youth Leadership Training in partnership with community groups/agencies.
- **Literacy Project** - Enhancing Early Childhood Literacy (0-5) by implementing and promoting a touch/read program - upstream strategy as this addresses building capacity for action and utilizes evidence based practice for early childhood development
- Increased hand washing campaign (Infection Control) for the public in all communi ties within the region.

Challenges

- Challenging health status issues that require ongoing engagement and capacity building with the community at large to ensure positive health outcomes. Capacity building tward community development is both labour and time intensive.

Goal 3: Retain, recruit, and train health providers

Recruitment and Retention

KYRHA at the Education and Career Expo in Meadow Lake, March 2007.

- Implemented and filled 3 Public Health Nurse senior student practicum positions, 2 in Ile a la Crosse and 1 in Buffalo Narrows. This resulted in 1 student being hired as a general duty RN position in Ile a la Crosse. Also filled 2 acute care student practicum positions in Ile a la Crosse resulting in 1 hire to a general duty RN position in Ile a la Crosse.
- The RHA also implemented and filled a nutritionist practicum student position for the region based in Buffalo Narrows.
- Ongoing participation in the provincial recruitment agency project provides broader access and interest to perspective employees through website and national career fairs.
- Continued Regional bursary program and summer student employment for residents enrolled in health related careers and employment opportunities upon completion of training program(s)
- Continuation of the EFAP program to assist staff and family in dealing with issues affecting work and home.
- Were at full capacity of General Duty RN positions in one facility for part of the year.

Staff Recognition

Annual staff recognition ceremonies were held in two general locations in the Region recognizing staff with 5 or more years of service.

Regional Wellness Coordinator

The recruitment of a Regional Wellness Coordinator has been instrumental in the increase of training opportunities. Some of these include the Respectful Workplace Workshops, with La Loche as the pilot site for the Provincial Initiative. Others are to include our Transfer, Lift and Repositioning program, Safety for Supervisor training, and training on Needle Safe Devices.

Sick time

The RHA has seen some improvements in sicktime usage of 10% from the previous year. This does not diminish the fact that it continues to contribute to excessive replacement costs at overtime rates.

Number of wage-driven premiums

The inability to recruit into the casual pool and our permanent positions result in a great deal of overtime being paid out. Overtime responsibility is then drawn from needed programs and services.

Number of lost time WCB days per 100 full time equivalents

The RHA has worked to increase awarness of Occupational Health and Safety responsibilites in the workplace. This has led to a decrease in claims over the past year.

Percentage of employees self-identifying as aboriginal

The RHA participates in the Aboriginal Employment Development Program tracking system. In 2005-2006, 74.6% of our employees self-identified to be Aboriginal. In March 2007,we reaffirmed our commitment to a representative workforce by signing the represenative workforce agreement. This year our data has shown a 2% increase in our workforce self-identifying to be Aboriginal for a total of 76.4%.

Pictured above: KY Bursary recipient Christina Morin of Ile a la Crosse from Ile-a-la-Crosse and is enrolled in her second year of the Nursing Education Program of Saskatchewan (NEPS) in Saskatoon.

Goal 4: A sustainable, efficient, accountable, quality health system

Accreditation

The Accreditation Survey was held in December 2006. As a result of the survey conducted by the Canadian Council on Health Services Accreditation, the RHA received Accreditation with Reports. The Self Assessment Teams created for preparation for the Accreditation Survey has now transitioned into the Quality Improvement Teams. A Quality and Performance Improvement Committee, which was created by the Board, oversees the Quality Improvement Teams.

The Board has set patient safety as a priority and has included this in the new strategic plan.

Client Concern Handling Process/ Risk Management

Awareness of the client concern handling process was on going throughout the year to ensure both clients and staff understand the concern handling process. Staff in-service on the Critical Incident reporting system and client safety occurrence reports (including near-misses) continued throughout the year in a variety of venues.

There were 53 **Client Concerns** received in 2005-06. Of these, 82% of the concerns were resolved were resolved within 30 days.

Dashboard Indicator: Percentage of critical incidents meeting timeframe for notification (3 days) for the RHA is 100% for the year 2006-2007.

David Seright (back row, far right) with fellow members of the Saskatchewan Provincial Advisory Committee of Older Persons during a meeting in Buffalo Narrows.

Financial Summary

The regions financial performance resulted in a surplus of $138,769.

A disproportionate amount of resources continues to be allocated to overtime costs. As a result, the region spent approximately $1.4 million on overtime, which is a significant portion of the operating budget. However, the overtime impact is mitigated through vacancy management resulting in savings of $700,000. Overtime issues continue to have a negative impact on the quality of service delivery.

The RHA continues to have financial challenges in ensuring adequate staff housing.

Additional funding of $400,000 and the pharmacy profit contribution of $200,000 were contributors to achieving the surplus.

The region is working diligently to develop solutions to alleviate operating and capital risks.

Dashboard indicators: The region can operate for 7.01 days on working capital. The operating surplus was 0.7% of total expenditures. Expenditures in the program support pool were well within the 12% threshold, at 10.5%.

The 2006 Defeat Diabetes Conference held in Beauval

Pictured directly above (L-R): Kristy Buchkowski, Community Dietician; Sandra Clarke, RN/Diabetes Educator; Carol Gillis; Elaine Malbeuf; Carla Bodnarus, CPNP/Public Health Nutritionist.

Top photo: A team from Dillon/Jans Bay participating on the 2006 Northern Diabetes Relay. The region-wide relay is held to raise awareness of diabetes and to promote a healthy active lifestyle.

Pictured above: Richard Petit presents a cheques on behalf of CIBN (Buffalo Narrows) to Ile a la Crosse Mayor Mel Morin (right), September 2006. The money was raised by CIBN through fundraising endeavors and will be placed in a fund coordinated by the Norther Village of Ile a la Crosse for furnishing and equipment for the new Integrated Services Facility.

Future Outlook/Emerging Issues

The region has specific values and principles it believes in which is outlined in the Keewatin Yatthé Regional Health Authority strategic plan.

The region wholeheartedly believes in community development in that it supports and builds on existing strengths and skills of the communities within the service area.

Keewatin Yatthé Regional Health Authority will endeavour to improve the Health Status of the residents by creating independence through self-reliance and personal responsibility. One of the key strategies has been our commitment to partnerships with organizations such as First Nations Health, Kids First North and other agencies that work in the human services area such as Community Resources and School Divisions. Influencing the determinants of health (such as lack of housing, unemployment, economics, social status, family, behaviours, and environment). etc) is not possible without the partnerships that the region has created. Because the determinants of health significantly impacts on service and program delivery, one of the key strategies in addressing these issues is the development and sustaining of these partnerships.

Signing the Representative Workforce Agreement on March 6, 2007 in Buffalo Narrows are: Minister Buckley Belanger, Tom McKnight (SGEU), Duane Favel (KYRHA Vice-Chair), and Alex Taylor (SAHO).

One of our key partnerships is with The Northern Health Strategy (NHS). The NHS brings together key Northern partners to the table and has many opportunities to discuss cross-jurisdictional issues that create barriers for clients who get caught between agencies. Through these opportunities for discussions, sound recommendations in the areas of chronic disease; mental health and addictions; oral health have been collected. It is essential that the Northern Health Strategy continue to follow through with the work (many times ground-breaking in nature) that has begun, and influences the future prospects of our RHA's performance.

Human Resources have been a tremendous struggle for us. Due to scarce human resources in acute care centers a disproportionate amount of resources has been allocated to this funding pool. As per the Accountability Agreement to maintain minimum requirements to operate northern hospitals, we are obligated to do so at a premium cost incurring huge overtime costs, reduced community based services as a result of recruitment and retention, which can poten-

Carol Gillis participates on a Safer Communities and Neighborhoods presentation of CILX.

tially compromise staff safety and patient care. Investment in long term training

initiatives can meet a significant part of the human resource needs in health service delivery. Also; as the region continues to see growth, the RHA will be competing for the same people, and it is vital that education meet health requirements.

There exists a number of challenges in achieving our objectives and along with emerging issues, they have been identified as follows:

Partnership Development – this requires a great deal of trust and commitment to a process, which takes a great length of time to develop and nurture to ensure sustainability. Due to the many issues as identified within the health status report the creation and commitment required will take a tremendous amount of human and financial resources.

The Recruitment and retention of staff – this has been and continues to be a significant challenge. The region is at a critical state in Registered Nursing (RNs) in the two Northern hospitals. We have had to close acute care beds for a period of time due to the lack of RNs. This is also the status of the laboratory staff at the La Loche and Ile a la Crosse facilities.

The ability to employ required professionals has been a daunting challenge. Because of this, the region faces risks in providing safety and competent patient care. Although we have managed our risks by working creatively and diligently to recruit and hire trained staff, the RHA need to be able to fill positions which provide support and leadership to front line staff in order to mitigate these risks.

KYRHA believes there is significant opportunity in our young population. With an increased number of youth entering the labour force, and an increase in high school graduates accessing postsecondary education, we have begun to focus increased energy in youth specific orientation (i.e. Project Hope, South Bay Youth Conference, Bursary Programs, and presentations at College and Career fairs in the region).

Although it is our hope that region residents accessing available bursaries and grants to enter postsecondary education will return, we still know that these trained individuals will be contributors wherever they decide to practice – whether it is "back home" or elsewhere in the province, and that as KYRHA invests in the people of the region, we are also investing in the province as a whole.

The RHA has also increased attention to retention rates and believes that we will see such a reflection of our efforts when we see success in our retention rates. Provincial grants can only assist us in our recruitment efforts, and the RHA is appreciative of such initiatives from the Saskatchewan Government.

Training of staff - in the areas where extreme shortages occur as indicated, staffing and maintaining the acute care site in most cases is contingent upon one RN who may be sick or other circumstances arise beyond the control of the region. Therefore, this may result in staff not receiving their training which can potentially become a huge risk to the region.

Staff shortage - is also one of the main reasons for excessive overtime. The region is required to call back RNs who have worked long hours with little rest. When RN's are expected to work a lot of overtime, this becomes a huge patient and staff safety issue. These risks have been identified as pressures and the region continues to work with the department on potential solutions. The region is able to recruit off shore nurses to make up the shortfall but at a very high price.

Staff Housing - is a major risk to the region. There continues to be a lack of housing for any staff that moves to the region, and at times only "cramped" accommodations are available. Because of this, the region has had to work with Saskatchewan Housing and the community to provide the housing it requires. This is a very long process and the need is now. The Province has provided $500,000 to help with housing and we are in the development stage with Saskatchewan Housing at this time. Sufficient and safe accommodations are essential in recruitment and most especially in retention.

Pictured above: Darren Lewis, IT Coordinator holds a training session for staff.

Office space - is a risk. Occupation Health and Safety issues around the state of the facilities impacts on the morale of our staff. The majority of the buildings we lease are through Saskatchewan Property Management and local owners, which makes the necessary upgrades or improvements very problematic. The Board has identified this as a priority and will continue to work-with the Department regarding solutions to replace existing buildings. Our office situation in Beauval has improved with the acquisition of additional space. Benefits such as such as solutions to privacy and over

crowding issues has improved staff morale due to these improved working conditions.

Homecare - has identified a few areas of risk and barriers to providing services and they are: participation and availability of training sessions. Often staff is required to travel out of region and the costs associated with travel are often quite high. Another risk identified is that the distance between communities is vast and there is concern when staff members are required to travel alone. This can sometimes be problematic particularly during inclement weather.

Mental Health and Addictions - staff makes every attempt to inform the residents in the region of the services that they have to offer. A marketing campaign outlining our inpatient addictions program was aimed at referral sources for our Northwest Addictions Centre. The coordinator of Mental Health and Addictions has made an effort to meet with community leaders in the region to let them know what services are available in their communities.

Project Hope – the risk we have faced and continue to face is the human resource arena. In the provision of Project Hope services, many of our staff employed in various areas of counseling, transferred in to Project Hope positions.

No direct physician services in the community of Green Lake - makes it difficult to obtain recent lab and medical information.

Dietitian Services - the increasing number of referrals for out patient dietitian counseling means more days per month required for outpatient clinics. Current wait time for dietitian services varies between 1 and 3 months depending on community and urgency of referral.

Regional position limits ability of clients to access dietitian services within their community more regularly. The regional dietitian is providing phone appointments for clients requesting follow-up in between community visits.

Difficulty in booking appointments for dietitian referrals from satellite communities. Appointments must be arranged for days when taxi services are provided and often clients do not have coverage for taxi. Chart reviews will need to be completed prior to visit as medical information not accessible in satellite communities.

Nutritionist Services - Nutrition screening and programming is currently not utilized in long-term care. Discussion has been initiated to develop plans for integrating dietitian services into long term care.

Region residents do not get the benefits of public health nutrition services such as healthy food policies, food security initiatives, nutrition education, practical nutrition services such as cooking classes, grocery store tours, etc. which will help to prevent diabetes and other nutrition related diseases in the long run (upstream programming). The focus still seems to be on treatment when we need to prevent these diseases, especially when the majority of the population is under 25. If we do not do a solid job of prevention now, we will be unable to keep up with the treatment demands in the future. Recruitment and retention make the execution of the initiative challenging.

The overwhelming workload of the nutritionist position will make it difficult to retain staff. The professional's job satisfaction decreases when the workload is unrealistic.

Edith Munsters, CLXT at the La Loche Health Centre.

Food Services - Limited quality assurance and risk management protocols in place for food services. Concerns have been communicated to management and a plan of action has been developed.

Demographic trends – there exists a significant youth population. According to the Saskatchewan Covered Population 2006, 30% of the population is between the ages of 0-14 years 20% of the population is between the ages of 15-24 years, and we have an increasing number of residents between the ages of 40-65years (an up). Research also shows an increase in diabetes, heart disease, and injuries, and the RHA has acted to address this through health promotion and community development initiatives. This process aligns with our strategic direction and paradigm of "Wholistic Health" by giving people the tools to have more input and opportunities to take responsibility into improving their own health. Partnership with the Northern Health Strategy's Chronic Disease Management initiatives has also proven beneficial.

Demographics also show heart disease, diabetes, and injury as the three prevalent trends in the region. The RHA would need to realign resources to better target these areas. Involvement with the Population Health Promotion Strategy is a major initiative currently underway to give attention to the areas of disease prevention and health promotion, but in order to truly impact the health status of our region residents, the RHA would need to realign resources to better target the areas where the major trends exist, and increased resource allocation would

be required. With an increase in type 2 diabetes, and with only one Diabetes Educator for the entire region, the RHA has struggled with the overwhelming demands to accommodate for this need.

With an influx in population migration (and according to the predictions of Buffalo Narrow Economic Development: an even greater rate of growth in the years ahead), and the continued recruitment and retention challenges, there is a risk in disruption to services that may result in the closing of facilities.

The reality of an aging management means that the RHA will need to begin to invest in succession planning initiative.

Sharon Taylor, HR Support Services (pictured above, far right) and coordinator of the monthly Staff Orientation Sessions with a group of new orientation participants during a session held in La Loche.

Increase infectious diseases – there is an overall issue of MRSA, TB, STI, and infection control throughout the north. Data gathered through the Population Health Unit shows an increase in TB. Due to the lack of a TB (Public Health) Nurse at the La Loche Health Centre, the region has only been able to maintain the status quo... The RHA has not had the opportunity to truly address this risk through the development of a TB outbreak management prevention initiative. Such an initiative would involve assessing potential TB cases through involvement through community education (i.e. house-to-house reviews) and the testing of sputum as a community based early detection strategy.

During the 2006-07 year, there was a major outbreak of communicable disease at one of our largest communities. The community acquired pneumonia and invasive pneumococcal disease which taxed an already stressed public health system. As the RHA was currently experiencing difficulty in recruiting a public health nurse to the specific health centre, meant that the community was already behind on public health prevention initiatives, and was therefore unable to respond as quickly to the crisis as we could have. This crisis situation illustrated the importance of the public health system and its broad reaching impacts. Through this experience, the RHA was also put through a mini-exercise as it relates to pandemic planning with the realization that due to our lack of internal capacity, we had to rely quite heavily on outside public health support.

To mitigate these risks, the region would be greatly helped with the recruitment of a Public Health Nurse focused on addressing TB issues and a full-time Pandemic Planner (as exists in other locations).

Accreditation – the accreditation process has led the RHA to highlight Patient Safety in the strategic plan of 2007-08. It is also anticipated that this strategic plan will bring new direction resulting in organizational change, moving the RHA from a segregated approach to an integrated approach. The accreditation process also brought to attention the need of skill assessment/development of acute care staff, and the need of facility assessments and using this information for improvement.

Connector road to Ft. Mac Murray – We understand there are many potential benefits to the predicted developments in our region with the development of the connector road, increased exploration for and extraction of our mineral or oil resources, increased community growth, etc. Caution and good planning is required however in order to minimize some of the potential accompanying downside of development.

KYRHA Patsy Laliberte (left) and Deborah Lalibere participate at the North of 54 conference. They are pictured here in a skit illustrating healthy/unhealthy relationships.

With the development of the road comes an increased expectation of the RHA to provide required emergency services for a significantly expanded population. If the profit companies (i.e. mining companies) were to create their own Emergency Medical Services, then the RHA also faces tremendous risk in competition for Human Resources as the RHA will struggle to compete with the salary and benefits a profit company is able to offer.

We believe that a comprehensive environmental impact assessment will help to ensure that the entire population benefits from increased economic development. For example, impact studies conducted for the road to Stony Rapids and Wollaston Lake – places where no roads previously existed. The study was done to show what potential impacts the road would have to the environment (including how to protect the water and water systems); what potential impact there would be on highway traffic; what chemicals would be transported; what potential safety issues should there be concern about; and potential social impacts. A comprehensive environ mental impact study/assessment of other communities is incredibly valuable for developers to

study. Such assessments could show expectations and raise awareness of what may happen by having a new road come in.

There would also be great value in working together with government (both Saskatchewan and Alberta) in looking at the idea of a comprehensive assessment of potential environmental impacts (both the positive and negative impacts in the community) in order to maximize the benefits and to minimize risks. Although we cannot eliminate the risk of things such as the increased chance of social disruption or increased motor vehicle accidents because of increased road traffic, there are measures we can take to minimize potential risks. We can also work towards maximizing economic benefits through education and training in the West Side.

In order for Keewatin Yatthé to plan better, it would be of tremendous benefit to be equipped with the information that a Comprehensive Impact Study would provide. Understanding the cumulative implications of the economic, environmental, demographic, health services, education services, and housing issues are significant in facing the future. We believe that if a Comprehensive Environmental Impact Study were considered, we can safeguard our communities from getting in the situation of uncontrolled development and all the resulting negative cumulating impacts.

Included in KYRHA's environmental scan in our Operational Plan of the past two years, has been the identification of the potential challenges and risks of the development of the connector road to Ft. Mac Murray. In our 2007-2008 Operational Plan, this was included as one of the top three challenges this region will encounter due to population increase (which is forecasted to be quite dramatic), inadequate resourcing, etc. We have predicted that the construction of the road to Ft. Mac Murray, the increasing emergence of exploration companies, and further developments, would, in the area of Health Services Impact and Delivery, require additional support services, equipment, and travel resources in order to provide an operational system which is stable and able to effectively cope with these existing and forecasted increase of demands effectively – in the area of acute care, ambulatory care, and public and environmental health.

In spite of the many risks and challenges KYRHA faces, it is important to note that the Board, Management, and Staff have worked hard to build and put in place a good administrative structure which was put through the Accreditation Process under the Canadian Council on Health Services Accreditation last December. KYRHA is incredibly pleased to share that our results were made known in February, with the Health Authority being granted Accreditation – with Report, which is something that we are very proud to have accomplished!

Board of Directors

Three new members were added to the Board of the Keewatin Yatthé Regional Health Authority during the 2006-2007 year.

- Arthur Daigneault, retired resident of Buffalo Narrows, was appointed as Board Member in February 2006. Mr. Daigneault also sits as the representative to the SAHO Board.

- Duane Favel, of Ile a la Crosse, was appointed in February 2006 and was elected Vice Chairman of the Board shortly after in March 2006. In addition, Mr. Favel sits as the representative to the Governance Committee, and is also currently the acting Mayor of the Northern Village of Ile a la Crosse.
- Board Member David Seright was appointed Chairperson of the Board in March 2006.

The Board maintained an active presence in the various activities and events held in the Health Region throughout the year.

KYRHA Board Members:

Back row (left - right)
Tina Rasmussen, Green Lake
Duane Favel (Vice Chair), Ile-a-la-Crosse
Lester Herman, La Loche
Yvette Morin, Ile-a-la-Crosse
John Janvier, La Loche
Dorah Montgrande, Dillon

Front row (left - right)
David Seright (Chairman), Buffalo Narrows
Annette Montgrand, La Loche
Arthur Daigneault, Buffalo Narrows
Gloria Apesis, Patuanak

Not in the photo:
Stella Laliberte, Beauval

Governance and Transparency

The Keewatin Yatthé Regional Health Authority (KYRHA) is responsible for the planning, organization, delivery, and evaluation of the Wholistic Health Services within the geographical area known as the Keewatin Yatthé Health Region. The Authority sets the direction through its strategic plan and through its monthly meetings with management and public.

KYRHA is a twelve-member board with cross regional representation. Keewatin Yatthé does not have any formal committees as all discussions occur with the entire board (committee of the whole) in attendance. Board committees if required, are established on an ad hoc basis to deal with specific issues as they arise.

The Chief Executive Officer (CEO) reports directly to the board and is responsible for establishing, recommending, and monitoring all operations under the KYRHA.

The Senior Management team works closely with the CEO and is comprised of the Directors of: Primary Health Services, Community Health Services, Human Resources, Finance, and Corporate Services.

The following is a list of activities that the region has done to become transparent:

- Board meetings are open to the public and are advertised in local newspapers and media outlets in English, Cree, and Dene.
- Board Notes are made available both internally and externally to share the formal discussions and resolutions made during the monthly board meetings.
- Meetings are scheduled with community leaders on a quarterly basis. This framework is the composition of the region's community advisory network. The community leaders are given the opportunity to give input and feedback to the board. The Board and Management use the meetings to provide information and updates on programs and services and to introduce initiatives and ideas.
- The use of newsletters (both internal and external), news releases, and posting information on the website further enhances public transparency.
- The annual report is distributed across all areas in the region to enhance awareness on the regions' activities.
- Managers, coordinators, and front-line service providers attend interagency meetings to gain insight into community issues and to be involved in a team approach to community healing.

- Day Programs, Wellness Clinics, and Friendship Days are provided on a regular basis giving the individual person in attendance an opportunity to come out and enjoy the company of other individuals attending these events. Events are schedules monthly and posted on local radio stations and within the local communities. Events are focused on health promotion and disease prevention.
- The region has many partnerships developed.
- Individual requests for information
- The commencement of reporting to taxi operators about the allocation of trips.
- Providing a Payee Disclosure List as requested by the Saskatchewan Government
- Policies are in all facilities and would be available to the general public, should they request in the proper manner.

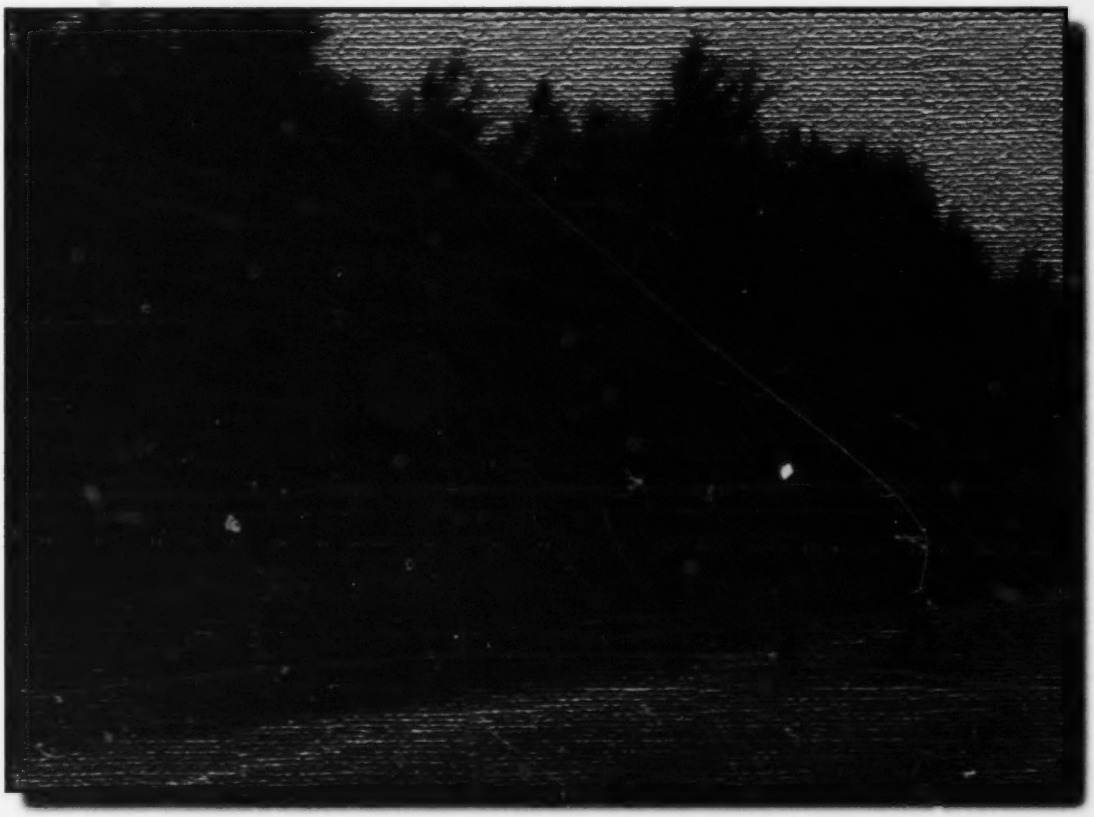
1. Representative workforce strategy is in the Human Resource policy
2. Hiring processes are detailed in the Collection Bargaining Agreement and Human Resource Policy.

Performance Management Summary

In support of **The Action Plan for Saskatchewan Health Care**, Saskatchewan Health developed an accountability framework and accountability documents with each health region that define and clarify the performance relationship between the authorities and the province. In addition to articulating organizational and program expectations of the RHA's, the accountability documents also link these expectations with funding and with performance indicators-measures of progress towards, and achievement of, the expectations.

To demonstrate accountability and transparency to the public, these indicators are publicly reported through this summary table in each region's annual report. For further information on technical interpretations and definitions of the indicators below, refer to the **Performance Management** document on the Saskatchewan Health website at:

www.health.gov.sk.ca



Indicator		RHA Value	Provincial Value	Range	Target
Organizational Effectiveness Indicators					
Quality					
Date of last CCHSA accreditation or when accreditation is scheduled *as of March 2007*		December 2006	*not applicable*	*not applicable*	*December 2009*
Date when the RHA participated in the Institute for Safe Medication Practices (ISMP) Canada "Hospital Medication Safety Self-Assessment", or when participation is planned *as of March 2007*		*not applicable*	*not applicable*	*not applicable*	*to be determined*
Number of client contacts with the Quality of Care Coordinator to raise a concern *2005/2006*		53	*not applicable*	*not applicable*	*not applicable*
Percentage of concerns raised with a Quality of Care Coordinator concluded within 30 days *2005/2006*		82%	86%	66% – 99%	*to be determined*
Workforce Planning					
The number of positions sitting vacant for periods longer than six months *[indicator to be developed]*		———	———	———	———
Distribution of health system full time equivalents (FTEs) by affiliation *2006/2007*	Provider Unions (CUPE, SEIU, SGEU)	132.37	*not applicable*	*not applicable*	*not applicable*
	HSAS	34.78			
	OOS/OTHER[1]	20.72			
	SUN	35.93			
	RWDSU[2]	*not applicable*			
	Organization as a whole	223.80			

Indicator		RHA Value	Provincial Value	Range	Target
Number of wage-driven premium hours (overtime and other premiums) per full time equivalent (FTE) by affiliation *2006/2007*	Provider Unions (CUPE, SEIU, SGEU)	91.10	36.85	16.36 – 91.10	*65*
	HSAS	117.97	25.44	0.25 – 117.97	*85*
	OOS/OTHER[1]	1.77	3.46	0.00 – 16.92	*0*
	SUN	368.66	81.54	27.14 – 368.66	*350*
	RWDSU[2]	*not applicable*	*not applicable*	*not applicable*	*Not applicable*
	Organization as a whole	131.56	42.47	17.19 – 131.56	*100*
Worked hours as a percentage of total hours by affiliation *2006/2007*	Provider Unions (CUPE, SEIU, SGEU)	73.1%	78.3%	73.1% – 80.7%	*75%*
	HSAS	75%	80.8%	75.0% – 83.9%	*80%*
	OOS/OTHER[1]	79.4%	82.5%	76.4% – 84.5%	*80%*
	SUN	63.7%	74.7%	63.7% – 77.9%	*67%*
	RWDSU[2]	*not applicable*	*not applicable*	*not applicable*	*Not applicable*
	Organization as a whole	72.5%	78.1%	72.5% – 80.7%	*75.5%*
Number of sick leave hours per full time equivalent (FTE) by affiliation *2006/2007*	Provider Unions (CUPE, SEIU, SGEU)	107.61	89.78	71.62 – 107.61	*100*
	HSAS	92.53	65.62	44.65 – 92.53	*85*
	OOS/OTHER[1]	51.41	47.34	27.68 – 61.46	*45*
	SUN	67.55	89.34	63.83 – 96.84	*60*
	RWDSU[2]	*not applicable*	*not applicable*	*not applicable*	*Not applicable*
	Organization as a whole	93.63	84.12	64.15 – 93.63	*73*
Number of lost-time WCB claims per 100 full time equivalents (FTEs) *2006/2007*		6.26	7.67	0.53 – 10.00	*7*
Number of lost-time WCB days per 100 full time equivalents (FTEs) *2006/2007*		430.74	468.45	38.43 – 766.40	*400*

Indicator		RHA Value	Provincial Value	Range	Target
Percentage of employees self-identifying as Aboriginal *2005/2006*[4]		74.6%	*not available*	*not applicable*	*80%*
Number of clinical placements offered and taken within the region / SCA *[indicator to be developed]*		———	———	———	———
Financial					
Surplus (deficit) *2006/2007*		$138,769	*not applicable*		$0
Surplus (deficit) as a percentage of actual operating expenditures *2006/2007*		0.7%	*not applicable*		0.0% – 0.5%
Working capital ratio (current ratio) *2006/2007*		1.75	*not applicable*		*to be determined*
Number of days able to operate with working capital *2006/2007*		7.01	*not applicable*		*to be determined*
Communications and Issues Management					
Key activities undertaken by RHA to address public confidence reported *2006/2007* *[yes/no indicator]*	Q1	Yes	*not applicable*	*not applicable*	significant activity is expected annually, but need not be reflected quarterly
	Q2	Yes			
	Q3	Yes			
	Q4	Yes			
Capital					
Annual equipment maintenance costs as a percentage of annual equipment replacement costs *[indicator to be developed]*		———	———	———	———

Indicator	RHA Value	Provincial Value	Range	Target
Program-Specific Indicators				
Province-Wide Services				
Number of patients as a percentage of agreed on target for magnetic resonance imaging (MRI) services[5] *2006/2007*	*not applicable*	102.4%	101.2% – 103.3%	100%
Number of exams as a percentage of agreed on target for magnetic resonance imaging (MRI) services[5] *2006/2007*	*not applicable*	90.6%	85.9% – 93.1%	100%
Number of actual hours of operation for magnetic resonance imaging (MRI) services[5] *2006/2007*	*not applicable*	*not applicable*	*not applicable*	*to be determined*
Number of patients as a percentage of agreed on target for computed tomography (CT) services[6] *2006/2007*	*not applicable*	98.0%	93.5% – 111.0%	100%
Number of exams as a percentage of agreed on target for computed tomography (CT) services[6] *2006/2007*	*not applicable*	107.3%	73.5% – 125.6%	100%
Number of actual hours of operation for computed tomography (CT) services[6] *2006/2007*	*not applicable*	*not applicable*	*not applicable*	*to be determined*
Number of patients as a percentage of agreed on target for bone mineral densitometry (BMD) services[5] *2006/2007*	*not applicable*	90.5%	78.4% – 101.7%	100%
Number of actual hours of operation for bone mineral densitometry (BMD) services[5] *2006/2007*	*not applicable*	*not applicable*	*not applicable*	*to be determined*

Indicator		RHA Value	Provincial Value	Range	Target
Number of patient years of dialysis provided in the current fiscal year[7] *2006/2007*		*not applicable*	*not applicable*	*not applicable*	*to be determined*
Current fiscal year's chronic kidney disease services levels as compared to previous fiscal year's levels[8] *As at December 31, 2006*	Number of chronic renal insufficiency patients	*not applicable*	*not applicable*	*not applicable*	*to be determined*
	Number of peritoneal dialysis patients	*not applicable*			
	Number of home unit chronic hemodialysis patients	*not applicable*			
	Number of north/ south chronic hemodialysis patients	*not applicable*			
Average wait time for admission to Saskatchewan Hospital North Battleford (SHNB)[9] *2005/2006*		*not applicable*	*not applicable*	*not applicable*	*to be determined*
Length of stay efficiency of inpatient rehabilitation programs – Wascana Rehabilitation Centre and Saskatoon City Hospital[10,11] *2005/2006*	Stroke	*N/A*	*not applicable*	*not applicable*	*to be determined*
	Brain Dysfunction	*N/A*			
	Spinal Cord Dysfunction	*N/A*			
	Orthopaedic Conditions	*N/A*			
	Neurological Conditions	*N/A*			
	Amputation of Limb	*N/A*			
	Major Multiple Trauma	*N/A*			
	Medically Complex	*N/A*			
	Debility	*N/A*			
	Cardiac	*N/A*			
	Pulmonary	*N/A*			
	Arthritis	*N/A*			
	Pain Syndrome	*N/A*			
	Other	*N/A*			
Alcohol and drug inpatient treatment completion rate per 100 admissions – Calder Centre[12] *2005/2006*	Child / Youth	-[14]	*not applicable*	*not applicable*	*to be determined*
	Adult	66.7%			
Acute Care					
Percentage of surgical cases performed as day surgery[13] *2006/2007*		*not applicable*	56.3%	39.1% – 74.8%	*not applicable*

Indicator		RHA Value	Provincial Value	Range	Target
Number and percentage of surgical cases on wait list that have already waited over 12 months[13] *2006/2007*	Number	*not applicable*	*not applicable*	*not applicable*	*not applicable*
	Percentage	*not applicable*	19.9%	0.0% – 23.8%	10%
Number and percentage of surgical cases on wait list that have already waited over 18 months[13] *2006/2007*	Number	*not applicable*	*not applicable*	*not applicable*	*not applicable*
	Percentage	*not applicable*	9.5%	0.0% – 12.0%	0%
Percentage of Priority Level I, II, III and IV surgical cases completed within target time frames[13] *2006/2007*	Priority Level I within 3 weeks	*not applicable*	57.3%	43.7% – 97.4%	95%
	Priority Level II within 6 weeks	*not applicable*	43.8%	0.0% – 96.6%	90%
	Priority Level III within 3 months	*not applicable*	63.9%	43.3% – 100.0%	90%
	Priority Level IV within 12 months	*not applicable*	88.0%	79.3% – 100.0%	90%
Cumulative number of surgical cases performed as a percentage of target and variance from target[13] *2006/2007*	Percentage of target	*not applicable*	98.3%	85.2% – 122.4%	100%
	Variance from target	*not applicable*	*not applicable*	*not applicable*	*not applicable*
Institutional Supportive Care					
Average wait time between approval for placement and placement for institutional supportive care services *[indicator to be developed]*		———	———	———	———
Prevalence of pressure sores: percentage of institutional supportive care residents with pressure sores[14] *as at the end of Q2 2006/2007*		-[14]	21.94%	16.47% – 28.28%	*to be determined*
Case mix index for institutional supportive care facilities[14] *as at the end of Q2 2006/2007*		*not applicable*	0.771	0.725 – 0.800	*to be determined*
Home-Based Supportive Care					
Case mix index for supportive home care services *[indicator to be developed]*		———	———	———	———

Indicator		RHA Value	Provincial Value	Range	Target
Average wait time between referral and assessment for supportive home care services *[indicator to be developed]*		———	———	———	———
Average wait time between assessment and commencement of supportive home care services *[indicator to be developed]*		———	———	———	———
Population Health Services					
Percentage of off reserve schools that are implementing health food nutrition policies *as of September 1, 2006*		20%	*not applicable*	0.0% – 27.3%	60% of schools by September 2011
Exclusive breastfeeding rates[15] *2005*		17.54	21.28%	13.64% – 40.11%	*to be determined*
Percentage of eligible population registered in SIMS and receiving recommended immunization at second birthday[16] *July 1, 2005 to June 30, 2006*	Diphtheria	72.7	73.5%	50.0% – 87.2%	*to be determined*
	Measles	75.8	72.5%	67.9% – 86.1%	
Influenza immunization rate per 100 population (age 65 years and over) *2005/2006*		56%	66%	46% – 77%	*to be determined*
Percentage of licensed or regulated facilities inspected each year (pursuant to *The Public Health Act*)[15] *2005/2006 and 2006/2007*	FEE – Food Eating Establishment	52 75	*not applicable*	45% – 100% 71% – 100%	80% – 100%
	FPL – Food Processing (Licensed)	20 67	*not applicable*	20% – 100% 67% – 100%	
	LA – Licensed Accommodations	31 76	*not applicable*	31% – 100% 52% – 100%	
	SP – Swimming Pools	62 45	*not applicable*	43% – 100% 45% – 100%	
	Public Water Supplies	31 72	*not applicable*	20% – 100% 18% – 100%	

Indicator		RHA Value	Provincial Value	Range	Target
Percentage of genital chlamydia cases with complete or required surveillance information in the electronic provincial surveillance system within established time frames *[indicator to be developed further]*		—	—	—	—
Percentage of facilities in compliance with *The Tobacco Control Act* in the category that includes: billiard halls / bingo establishments / bowling centres / casinos / restaurants / taverns *[data is currently not available due to system implementation issues]*		—	—	—	90% compliance
Percentage of population (age 12 years and over) who are current (daily or occasional) smokers[15] *2005*	Males	41.75%	25.13%	19.95% – 41.75%	*to be determined*
	Females	32.31%	23.30%	16.36% – 32.31%	
Community Care Services					
Average wait time between initial contact and first face-to-face contact for outpatient child and youth mental health services *[indicator to be developed]*		—	—	—	—
Average wait time between initial contact and first face-to-face contact for outpatient adult community mental health services *[indicator to be developed]*		—	—	—	—
Average wait time between initial contact and first face-to-face contact for outpatient psychiatric rehabilitation mental health services *[indicator to be developed]*		—	—	—	—
Alcohol and drug outpatient treatment completion rate per 100 admissions *2005/2006*		49.2%	59.7%	41.8% – 72.2%	*to be determined*

Indicator	RHA Value	Provincial Value	Range	Target
Average wait time for admission to alcohol and drug outpatient services *[data not available]*[17]	____	____	____	____
Problem gambling treatment completion rates per 100 admissions *[indicator to be developed]*	____	____	____	____
Home-Based Acute and Palliative Care				
Average wait time between referral and assessment for acute and palliative home care services *[indicator to be developed]*	____	____	____	____
Average wait time between assessment and commencement of home-based acute and palliative care *[indicator to be developed]*	____	____	____	____
Percentage of palliative home care clients with unresolved pain *[indicator to be developed]*	____	____	____	____
Percentage of palliative home care clients who choose to die at home and receive services in support of that option *[indicator to be developed]*	____	____	____	____
Percentage of patients discharged from acute care to home care with post-acute discharge plan in place on discharge *[indicator to be developed]*	____	____	____	____
Primary Health Services				
Percentage of RHA population with geographic proximity to primary health care teams *March 2007*	100%	19.98%	0.00% – 100.00%	25% of SK residents by 2006, 100% by 2011

Indicator		RHA Value	Provincial Value	Range	Target
Number of discrete clients receiving primary health care services in the RHA *2006/2007*	Q1	3332	*not applicable*	*not applicable*	*not applicable*
	Q2	4240			
	Q3	1996			
	Q4	3267			
Number of Healthline calls for the RHA *2006/2007*	Q1	156	*not applicable*	*not applicable*	*not applicable*
	Q2	154			
	Q3	160			
	Q4	193			
	Year as a whole	663			
Total number of new primary health care teams developed in the current year *2006/2007*		0	*not applicable*	*not applicable*	*not applicable*
Emergency Response Services					
Percentage of calls where the maximum qualification of all personnel on the call was less than Emergency Medical Technician (EMT) *2005/2006*		17.97%	0.73%	0.00% – 17.97%	*15%*
Mental Health and Addiction Services					
Average length of stay of mental health inpatients[18] *2005/2006*		*not applicable*	15.4	10.1 – 19.8	*to be determined*
Mental health inpatient readmission rate per 100 mental health inpatients[18] *2005/2006*		*not applicable*			*to be determined*
Alcohol and drug inpatient treatment completion rate per 100 admissions[19] *2005/2006*		55.9%	69.1%	55.9% – 72.6%	*70%*
Average wait time for admission to alcohol and drug inpatient services[20] *February and March 2007*[17]		12.9	*not applicable*	*not applicable*	*10*
Average wait time for admission to alcohol and drug detoxification services[21] *February and March 2007*[17]		7.0	*not applicable*	*not applicable*	*to be determined*

Indicator		RHA Value	Provincial Value	Range	Target
Average wait time for admission to alcohol and drug stabilization services[22] *February and March 2007*[17]		*not applicable*	*not applicable*	*not applicable*	*to be determined*
Average wait time for admission to alcohol and drug long term residential treatment services[23] *[data not available]*[17]		———	———	———	———
Program Support Services					
Expenditures in program support funding pool as a percentage of total RHA operating expenditures *2006/2007*		10.5%	*not applicable*		12% for Mamawetan Churchill River and Keewatin Yatthé; 5% for all other RHAs
Health Status and Outcome Indicators					
Infant mortality rate per 1,000 live births[24] *2002-2004*		6.0	5.9	4.0 – 10.5	*A 3 yr average below the provincial rate*
Low birth weight rate per 100 live births[24] *2002-2004*		4.5	5.4	3.7 – 6.0	*to be determined*
High birth weight rate per 100 live births[24] *2002-2004*		24.5	15.7	12.9 – 31.1	*to be determined*
Potential years of life lost per 100,000 population (age 0 to 74 years)[15] *2001*[25]	Circulatory Diseases	861.2	951.5	817.9 – 1,208.9	*to be determined*
	All Malignant Neoplasms	1126.0	1,483.1	1,126.0 – 1,706.8	
	All Respiratory Diseases	165.7	222.9	63.5 – 376.5	
	Unintentional Injuries	2781.8	1,028.0	636.4 – 2,781.8	
	Suicide and Self-Inflicted Injuries	628.5	412.1	315.1 – 628.5	
Disability-free life expectancy (at birth)[15] *1996*[25]	Males	61.8	66.6	61.8 – 69.2	*to be determined*
	Females	63.2	70.0	63.2 – 72.5	
Disability-free life expectancy (at age 65 years)[15] *1996*[26]	Males	8.7	11.2	8.7 – 12.1	*to be determined*
	Females	8.4	12.7	8.4 – 13.2	

Indicator		RHA Value	Provincial Value	Range	Target
Life expectancy (at birth)[15] *2001[27]*	Males	72.1	76.2	72.1 – 78.2	*to be determined*
	Females	76.1	81.8	76.1 – 82.8	
Life expectancy (at age 65 years)[15] *2001[27]*	Males	15.6	16.9	15.6 – 18.0	*to be determined*
	Females	17.2	20.9	17.2 – 21.8	
Self-rated health status: percentage of population (age 12 years and over) who report their health as very good or excellent[15] *2005*		47.95%	52.35%	39.86% – 57.96%	*50%*
Percentage of population (age 18 to 64 years) who are overweight or obese[15] *2005*	Overweight (BMI 25.0-29.9)	33.91%	32.52%	30.53% – 36.12%	*Overweight 30%*
	Obese (BMI 30.0+)	24.19%	20.03%	16.88% – 24.19%	*Obese 21%*
Percentage of population (age 12 years and over) who report physical activity participation levels of active / moderately active or inactive[15] *2005*	Active / moderately active	53.35%	48.62%	38.60% – 53.35%	*55%*
	Inactive	44.06%	49.52%	44.06% – 58.77%	
Number of visits to a physician for a mental health reason *2005/2006*	General Practitioners	883	*not applicable*	*not applicable*	*not applicable*
	Psychiatrists	36			
Age-sex-adjusted diabetes prevalence rate per 1,000 population[28] *2004/2005*		95.8	*not applicable*	41.8 – 95.8	98.8 5 yr goal is to decrease the rate of increase
Injury hospitalization rate per 1,000 population (age 0 to 19 years) *2004/2005*	Males	12	10.4	7.3 – 27.0	*Males 10*
	Females	5.7	6.9	4.8 – 12.9	*Females 4*
Hospitalization rate due to falls per 1,000 population (age 65 years and over) *2004/2005*	Males	17.9	14.7	10.5 – 22.0	*Males 15*
	Females	28.5	26.6	19.9 – 38.0	*Females 25*

Notes:

Please refer to the document "Performance Management Accountability Indicators" for detailed indicator descriptions.

1 The OOS/OTHER category includes all non-unionized employees on the SAHO Payroll system, not just management personnel.

2 The RWDSU category is applicable to Regina Qu'Appelle only.

3 Benchmark development is still in progress for the workforce planning indicators. In the interim, it is suggested that the provincial value or that of the best performer be used as the target.

4 The most recent data for the "Percentage of employees self-identifying as Aboriginal" indicator is from 2005/2006, and is not available for Five Hills, Cypress, Heartland, Prairie North, the Saskatchewan Cancer Agency, or the province as a whole.

5 MRI and bone mineral densitometry indicators are applicable to Regina Qu'Appelle and Saskatoon only.

6 CT indicators are applicable to Cypress, Five Hills, Prairie North, Prince Albert Parkland, Regina Qu'Appelle, Saskatoon, and Sunrise only.

7 Patient years of dialysis indicator is applicable to Cypress, Five Hills, Regina Qu'Appelle, Saskatoon, Kelsey Trail, Prairie North, Prince Albert Parkland, and Sunrise only.

8 Chronic kidney disease services indicator is applicable to Regina Qu'Appelle and Saskatoon only.

9 SHNB indicator is applicable to Prairie North only.

10 "Length of stay efficiency of inpatient rehabilitation programs" indicator is applicable to Regina Qu'Appelle (Wascana Rehabilitation Centre) and Saskatoon (Saskatoon City Hospital) only.

11 Wascana Rehabilitation Centre and Saskatoon City Hospital are not peer facilities, in terms of their inpatient rehabilitation programs. Therefore, their results should not be compared to each other.

12 "Alcohol and drug inpatient treatment completion rate – Calder Centre" is applicable to Saskatoon only.

13 The 2006/2007 target volume of surgeries to be performed by each RHA was negotiated between that RHA and Saskatchewan Health.

14 Due to the small number of institutional supportive care residents in Mamawetan Churchill River and Keewatin Yatthé, the case mix index and pressure sores indicators are not applicable to these regions.

15 Mamawetan Churchill River, Keewatin Yatthé and Athabasca Health Authority were grouped together as "Northern Health Regions" for this indicator.

16 The Saskatchewan Immunization Management System (SIMS) does not capture on-reserve immunizations.

17 Data collection through the Alcohol and Drug Client Information System (ADCIS) will start in April 2007. Results for alcohol and drug inpatient, detoxification, and stabilization services are based on data collected manually in February and March 2007 (Saskatoon detoxification data available for March 2007 only).

18 Mental health inpatient indicators are not applicable to Heartland, Keewatin Yatthé, Kelsey Trail, and Mamawetan Churchill River.

19 "Alcohol and drug inpatient treatment completion rate" is applicable to Keewatin Yatthé, Mamawetan Churchill River, Prairie North, Regina Qu'Appelle, and Saskatoon only.

20 "Average wait time for admission to alcohol and drug inpatient services" is applicable to Keewatin Yatthé, Mamawetan Churchill River, Prairie North, Prince Albert Parkland (youth services), Regina Qu'Appelle, and Saskatoon (both adult and youth services) only.

21 "Average wait time for admission to alcohol and drug detoxification services" is applicable to Five Hills, Keewatin Yatthé, Mamawetan Churchill River, Prairie North, Regina Qu'Appelle, and Saskatoon only.

22 "Average wait time for admission to alcohol and drug stabilization services" is applicable to Regina Qu'Appelle and Saskatoon only.

23 "Average wait time for admission to alcohol and drug long term residential treatment services" is applicable to Prairie North only.

24 Starting 2005/2006, the calculation methodology for the "Infant mortality rate", "Low birth weight rate" and "High birth weight rate" indicators changed from what was used previously. The time period also changed (three consecutive years, instead of five). Because these measures are calculated on a three-year basis, results are the same as those reported in 2005/2006.

25 Statistics Canada calculates this measure intermittently. The most recent is based on 2000 through 2002 death data and 2001 population estimates. Therefore, results are the same as those reported for 2005/2006.

26 Statistics Canada no longer calculates this measure (a similar measure, "Health Adjusted Life Expectancy (HALE)", exists but is not available at the regional level). Therefore, results are the same as those reported for 2004/2005 and 2005/2006.

27 Statistics Canada calculates this measure every 5 years, based on the latest census (2001). Therefore, results are the same as those reported for 2004/2005 and 2005/2006.

28 Starting 2005/2006, diabetes cases are determined using an enhanced version of the methodology (the prescription drug database is now used along with the hospital separations and physician services databases). Caution should be exercised if comparing results to those presented in the 2004/2005 summary. The age-sex-adjusted rates were calculated using 1996 Statistics Canada Census populations for Saskatchewan by sex and ten-year age groups.

MANAGEMENT REPORT

April 26, 2007

Keewatin Yatthé Regional Health Authority

REPORT OF MANAGEMENT

The accompanying financial statements are the responsibility of management and are approved by the Keewatin Yatthé Regional Health Authority. The financial statements have been prepared in accordance with Canadian Generally Accepted Accounting Principles and the Financial Reporting Guide issued by Saskatchewan Health, and of necessity include amounts based on estimates and judgments. The financial information presented in the annual report is consistent with the financial statements.

Management maintains appropriate systems of internal control, including policies and procedures, which provide reasonable assurance that the Region's assets are safeguarded and the financial records are relevant and reliable.

The Authority is responsible for reviewing the financial statements and overseeing Management's performance in financial reporting. The Authority meets with Management and the external auditors to discuss and review financial matters. The Authority approves the financial statements and the annual report.
The appointed auditor conducts an independent audit of the financial statements and has full and open access to the Finance/Audit Committee. The auditor's report expresses an opinion on the fairness of the financial statements prepared by Management.

Carol Gillis
Chief Executive Officer

M. Cook
Mark Cook
Chief Financial Officer

2006 - 2007 Financial Report

Canadian Generally Accepted Auditing Standards require the auditor appointed by the RHA review the annual report prior to release. The auditor's review is to ensure the financial statements and auditor's reports are adequately reproduced, and to ensure any other information presented within the report is consistent with the financial statements. Once the auditor has reviewed the annual report and determined it is accurate, they will provide the RHA with permission to include their signature in the annual report.

The complete set of financial statements must be included to promote transparency. As a result, this section included the:

- Auditor's Report – prepared and signed by the appointed auditor.
- Audited Financial Statements, Notes, and Schedules – signed by the Chairperson.

Fundraising for the Ile a la Crosse Integrated Services Facility, the Northern Village of Ile a la Cross host an ice-fishing derby.

2006 - 2007
Financial Report

MEYERS NORRIS PENNY LLP

AUDITORS' REPORT

To: The Keewatin Yatthé Regional Health Authority

We have audited the statement of financial position of the Keewatin Yatthé Regional Health Authority as at March 31, 2007 and the statements of operations and changes in fund balances, cash flows, and supporting schedules for the year then ended. These financial statements are the responsibility of the Keewatin Yatthé Regional Health Authority's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we plan and perform an audit to obtain reasonable assurance whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation.

In our opinion, these financial statements present fairly, in all material respects, the financial position of the Keewatin Yatthé Regional Health Authority as at March 31, 2007 and the results of its operations and its cash flows for the year then ended in accordance with Canadian generally accepted accounting principles.

Meyers Norris Penny LLP

Prince Albert, Saskatchewan
April 26, 2007

Chartered Accountants

KEEWATIN YATTHE REGIONAL HEALTH AUTHORITY
STATEMENT OF FINANCIAL POSITION
As at March 31, 2007

	Restricted Funds				
	Operating Fund	Capital Fund	Community Trust Fund	Total 2007	Total 2006
ASSETS					
Current assets					
Cash and short-term investments (Statement 3)	$ 4,113,246	$ 369,669	$ -	$ 4,482,915	$ 1,170,660
Accounts receivable					
Saskatchewan Health - General Revenue Fund	108,218	4,286,792	-	4,395,010	7,608,656
Other	914,304	78,064	-	992,368	707,897
Interfund receivables	-	1,397,921	-	1,397,921	911,357
Inventory	443,507	-	-	443,507	593,747
Prepaid expenses	77,813	-	-	77,813	57,047
	5,657,088	6,132,446	-	11,789,534	11,049,364
Investments	-	-	-	-	23,867
Capital assets (Note 3)	-	22,803,511	-	22,803,511	15,354,862
Total Assets	$ 5,657,088	$ 28,935,957	$ -	$ 34,593,045	$ 26,428,093
LIABILITIES & FUND BALANCE					
Current liabilities					
Accounts payable	$ 1,054,005	$ 1,779,856	$ -	$ 2,833,861	$ 1,993,710
Accrued salaries	410,652	-	-	410,652	683,019
Vacation payable	1,090,837	-	-	1,090,837	909,886
Interfund payables	1,397,921	-	-	1,397,921	911,357
Current portion of capital lease obligation	-	-	-	-	26,274
Deferred Revenue (Note 5)	1,316,023	-	-	1,316,023	937,008
	5,269,438	1,779,856	-	7,049,294	5,461,254
Long Term Liabilities					
Capital lease obligation	-	-	-	-	-
Total Liabilities	5,269,438	1,779,856	-	7,049,294	5,461,254
Fund Balances					
Invested in capital assets	-	22,303,511	-	22,803,511	15,328,587
Externally restricted (Schedule 3)	-	260,551	-	260,551	251,000
Internally restricted (Schedule 3)	-	4,092,039	-	4,092,039	5,138,371
Unrestricted	387,650	-	-	387,650	248,881
Fund balances – (Statement 2)	387,650	27,156,101	-	27,543,751	20,966,839
Total Liabilities & Fund Balances	$ 5,657,088	$ 28,935,957	$ -	$ 34,593,045	$ 26,428,093

Approved on behalf of the board of directors:

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(See accompanying notes to the financial statements)

KEEWATIN YATTHE REGIONAL HEALTH AUTHORITY
STATEMENT OF OPERATIONS AND CHANGES IN FUND BALANCES
For the Year Ended March 31, 2007

	Operating Fund			Restricted			
	Budget 2007 (Note 11)	2007	2006	Capital Fund 2007	Community Trust Fund 2007	Total 2007	Total 2006
REVENUES							
Saskatchewan Health - General Revenue	$ 17,468,928	$ 17,583,751	$ 17,075,154	$ 6,985,000	$ -	$ 6,985,000	$ 8,735,000
Other Provincial Revenue	-	-	-	-	-	-	-
Federal Government Revenue	75,000	75,000	90,200	-	-	-	-
Funding from other Provinces	-	-	-	-	-	-	-
Special Funded Programs	126,448	148,690	231,585	-	-	-	-
Patient Fees	794,000	877,935	846,889	-	-	-	-
Out of Province Revenue (Reciprocal)	6,885	3,330	74,137	-	-	-	-
Out of Country Revenue	-	-	-	-	-	-	-
Donations	-	-	-	290	-	290	251,000
Investment Revenue	15,000	74,192	27,231	13,547	-	13,547	3,480
Ancillary Revenue	627,000	2,061,138	1,984,652	-	-	-	-
Recoveries	319,310	362,544	343,690	-	-	-	-
Other Revenue	15,000	95,639	40,760	-	-	-	-
	19,447,571	21,282,219	20,714,298	6,998,837	-	6,998,837	8,989,480
EXPENSES							
Province Wide Acute Care Services	53,006	47,986	48,144	-	-	-	-
Acute Care Services	6,477,022	6,566,992	6,361,488	240,331	-	240,331	361,116
Physician Compensation - Acute	35,500	36,134	-	-	-	-	-
Supportive Care Services	898,265	1,091,328	970,587	211,769	-	211,769	194,182
Home Based Service - Supportive Care	1,020,227	1,078,992	-	-	-	-	-
Population Health Services	2,270,022	2,180,555	2,151,422	7,147	-	7,147	5,196
Community Care Services	1,802,190	1,467,408	1,270,486	-	-	-	-
Home Based Services - Acute & Palliative	-	-	949,364	1,176	-	1,176	1,033
Primary Health Care Services	1,746,305	2,229,584	2,115,596	16,296	-	16,296	14,681
Emergency Response Services	1,282,259	1,508,584	1,470,929	66,726	-	66,726	80,371
Mental Health Services	-	-	-	-	-	-	-
Addictions Services	674,281	655,041	667,702	-	-	-	154
Physician Compensation - Community	141,574	-	653,766	-	-	-	-
Program Support Services	2,228,311	2,210,497	2,201,319	83,917	-	83,917	86,132
Special Funded Programs	201,395	95,462	225,193	-	-	-	-
Ancillary	617,214	1,974,887	1,854,367	(66,668)	-	(66,668)	-
Total Expenses (Schedule 1)	19,447,571	21,143,450	20,940,363	560,694	-	560,694	742,865
Excess (Deficiency) of revenues over expenses	$ -	138,769	(226,065)	6,438,143	-	6,438,143	8,246,615
Fund Balances, beginning of year		248,881	474,946	20,717,958	-	20,717,958	12,471,343
Interfund transfers		-		-	-	-	-
Fund balances, end of year		$ 387,650	$ 248,881	$ 27,156,101	$ -	$ 27,156,101	$ 20,717,958

(See accompanying notes to the financial statements)

KEEWATIN YATTHE REGIONAL HEALTH AUTHORITY
STATEMENT OF CASH FLOW
For the Year ended March 31, 2007

	Operating Fund		Restricted Fund			
	2007	2006	Capital Fund	Community Trust Fund	Total 2007	Total 2006
Cash Provided by (used in):	**Operating Activities**		**Financing and Investing Activities**			
Excess (deficiency) of revenue over expenses	$ 138,769	$ (226,065)	$ 6,438,143	$ -	$ 6,438,143	$ 8,246,615
Net change in non-cash working capital (Note 6)	3,136,074	(883,801)	1,050,327	-	1,050,327	(3,618,518)
Amortization of capital assets	-	-	627,362	-	627,362	742,865
Investment income on long-term investments	-	-	-	-	-	-
Gain/(loss) on disposal of capital assets	-	-	(66,668)	-	(66,668)	-
	3,274,843	(1,109,866)	8,049,164	-	8,049,164	5,370,962
Purchase of capital assets						
Buildings/construction	-	-	(7,888,843)	-	(7,888,843)	(4,882,729)
Equipment	-	-	(192,178)	-	(192,178)	(207,639)
Proceeds on disposal of capital assets						
Buildings	-	-	-	-	-	-
Equipment	-	-	71,675	-	71,675	-
Disposal (Purchase) of long-term investment	23,867	(23,867)	-	-	-	-
	23,867	(23,867)	(8,009,345)	-	(8,009,345)	(5,090,368)
Repayment of debt	-	-	(26,274)	-	(26,274)	(27,114)
Net increase (decrease) in cash & short term investments during the year	3,298,710	(1,133,733)	13,545	-	13,545	253,480
Cash & short term investments, beginning of year	814,536	1,948,269	356,124	-	356,124	102,644
Interfund transfers	-	-	-	-	-	-
Cash & short term investments, end of year (Schedule 2)	$ 4,113,246	$ 814,536	$ 369,669	$ -	$ 369,669	$ 356,124
Amounts in cash balances						
Cash & short term investments	$ 4,113,246	$ 814,536	$ 369,669	$ -	$ 369,669	$ 356,124

(See accompanying notes to the financial statements)

1. Legislative Authority

On August 1, 2002, the Legislative Assembly passed *The Regional Health Services Act* (The Act). The Act created the Regional Health Authorities for the purpose of governing the delivery of health services as well as establishing and governing Health Regions in the province of Saskatchewan. The Keewatin Yatthé Regional Health Authority was created by the Act and is responsible for the planning, organization, delivery and evaluation of health services it is to provide within the geographic area known as the Keewatin Yatthé Health Region, under section 27 of The Act.

The Keewatin Yatthé Regional Health Authority is a non-profit organization and is not subject to income and property taxes from the federal, provincial, and municipal levels of government.

2. Significant Accounting Policies

These financial statements have been prepared in accordance with Canadian Generally Accepted Accounting Principles and include the following significant accounting policies:

a) Fund Accounting

The accounts of the Keewatin Yatthé Regional Health Authority are maintained in accordance with the restricted fund method of accounting for contributions. For financial reporting purposes, accounts with similar characteristics have been combined into the following major funds:

i) Operating Fund

The operating fund reflects the primary operations of the Regional Health Authority including revenues received for provision of health services from Saskatchewan Health - General Revenue Fund, and billings to patients, clients, the federal government and other agencies for patient and client services. Other revenue consists of donations, recoveries and ancillary revenue. Expenses are for the delivery of health services.

ii) Capital Fund

The capital fund is a restricted fund that reflects the equity of the Regional Health Authority in capital assets after taking into consideration any associated long-term debt. The capital fund includes revenues received from Saskatchewan Health - General Revenue Fund designated for construction of capital projects and/or the acquisition of capital assets. The capital fund also includes donations designated for capital purposes by the contributor. Expenses consist primarily of amortization of capital assets.

b) Revenue

Unrestricted contributions are recognized as revenue in the Operating Fund in the year received or receivable if the amount to be received can be reasonably estimated and collection is reasonably assured. Ancillary revenue and patient fees are recognized in the period for which the goods or services are provided.

Restricted contributions related to general operations are recorded as deferred revenue and recognized as revenue of the Operating Fund in the year in which the related expenses are incurred. All other restricted contributions are recognized as revenue of the appropriate restricted fund in the year.

c) Capital Assets

Capital assets are recorded at cost. Normal maintenance and repairs are expensed as incurred. Capital assets, with a life exceeding one year, are amortized on a straight-line basis over their estimated useful lives as follows:

Buildings	2 ½% to 5%
Land and leasehold improvements	10% to 20%
Equipment	5% to 33%

Donated capital assets are recorded at their fair market value at the date of contribution (if fair value can be reasonably determined).

d) Inventory

Inventory consists of general stores, pharmacy, laboratory and other. All inventories are valued at cost as determined on the first in, first out basis.

e) Investments

Investments are valued at the lower of cost or market.

f) Pension

Employees of the Keewatin Yatthé Regional Health Authority participate in several multi-employer defined benefit pension plans or a defined contribution plan. The Keewatin Yatthé Regional Health Authority follows defined contribution plan accounting for its participation in the plans. Accordingly, the Keewatin Yatthé Regional Health Authority expenses all contributions it is required to make in the year.

g) Measurement Uncertainty

These financial statements have been prepared by management in accordance with Canadian Generally Accepted Accounting Principles. In the preparation of financial statements, management makes various estimates and assumptions in determining the reported amounts of assets and liabilities, revenues and expenses and in the disclosure of commitments and contingencies. Changes in estimates and assumptions will occur based on the passage of time and the occurrence of certain future events. The changes will be reported in the period in which they become known.

Restricted contributions related to general operations are recorded as deferred revenue and recognized as revenue of the Operating Fund in the year in which the related expenses are incurred. All other restricted contributions are recognized as revenue of the appropriate restricted fund in the year.

c) Capital Assets

Capital assets are recorded at cost. Normal maintenance and repairs are expensed as incurred. Capital assets, with a life exceeding one year, are amortized on a straight-line basis over their estimated useful lives as follows:

Buildings	2 ½% to 5%
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Donated capital assets are recorded at their fair market value at the date of contribution (if fair value can be reasonably determined).

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h) Financial Instruments – Recognition and Measurement

In January 2005, the Canadian Institute of Chartered Accountants issued new recommendations for the recognition and measurement of financial instruments, and amendments to the existing presentation and disclosure standards, effective for interim and annual financial statements with fiscal years beginning on or after October 1, 2006. Section 3855 *Financial Instruments – Recognition and Measurement* establishes standards for recognizing and measuring financial assets, financial liabilities and non-financial derivatives. Section 3861 *Financial Instruments – Disclosure and Presentation* discusses the presentation and disclosure of these items. The application of hedge accounting is covered in Section 3865 *Hedges*. Section 1530 *Comprehensive Income* establishes standards for reporting and displaying certain gains and losses, such as unrealized gains and losses related to hedges or other derivative instruments, outside of net income, in a statement of comprehensive income. Although the requirements of Section 1530 *Comprehensive Income* are not applicable for not-for-profit organizations, amendments to Section 4400 *Not-For-Profit Organizations* will require presentation of gains, losses, revenues and expenses arising from derivatives, hedges and other financial instruments as separate components of the change in net assets. There have also been numerous consequential amendments made to other Sections.

In December 2006, the Canadian Institute of Chartered Accountants issued Section 3862 Financial Instruments – Disclosures and Section 3863 Financial Instruments – Presentation to replace Section 3861 Financial Instruments – Disclosure and Presentation. These new Sections are effective for interim and annual financial statements with fiscal years beginning on or after October 1, 2007, but may be adopted in place of Section 3861, before that date.

The Regional Health Authority has not yet determined the effect of these new standards on its financial statements. However, it does not expect the adoption of these new standards to have a material impact on its financial statements.

3. Capital Assets

	March 31, 2007			March 31, 2006
	Cost	Accumulated Amortization	Net Book Value	Net Book Value
Land	$ 20,170	$ -	$ 20,170	$ 20,170
Leasehold Improvements	26,979	26,979	-	-
Buildings	11,012,646	2,882,941	8,129,705	8,534,302
Equipment	3,500,091	2,793,258	706,833	738,613
Construction in Progress	13,946,803	-	13,946,803	6,061,777
	$ 28,506,689	$ 5,703,178	$ 22,803,511	$ 15,354,862

4. Commitments

a) Capital Asset Acquisitions

At March 31, 2007 commitments for acquisition of capital assets were $762,897 (2006 - $782,415). The Regional Health Authority has signed an agreement with the Department of Education to build a joint use facility in the Northern Community of Ile a la Crosse. The Regional Health Authority's share of the expected project costs are $17,477,775 (building and equipment), with the Department of Health committing to grant $16,682,475 to the Regional Health Authority. The Regional Health Authority must comply with various reporting and performance restrictions regarding the Department of Health grant. Construction of this new integrated facility is underway in the Northern community of Ile a la Crosse. At March 31, 2007 total construction costs incurred were $13,946,803.

b) Operating Leases

Minimum annual payments under operating leases on property and equipment over the next five years are as follows:

2008	$ 752,144
2009	$ 773,957
2010	$ 773,957
2011	$ 751,946
2012	$ 751,946

5. Deferred Revenue

	Balance Beginning of Year	Less Amount Recognized	Add Amount Received	Balance End of Year
Sask Health Initiatives				
Diabetes Plan	$ 1,410	$ -	$ -	$ 1,410
Paramedic Prgm	15,250	12,000	-	3,250
Professional Development	21,229	11,400	55,330	65,159
Team Development	57,092	20,002	-	37,089
Health Promotion	10,784	10,784	-	-
HIPA	27,400	1,225	-	26,175
Home Care Surgical Waitlist	3,000	3,000	-	-
St. Joseph's Hospital Move	-	-	125,000	125,000
Primary Care ILX	180,438	92,594	-	87,844
Primary Care - Team Development	-	-	40,067	40,067
EMT Training	3,507	3,507	-	-
Healthline	4,000	1,603	-	2,397
Retention Recruitment La Loche Liv Qtrs	500,000	-	65,000	565,000
Aboriginal Awareness Training	12,200	-	-	12,200
Needle Exchange	4,000	4,140	4,000	3,860
SESDs	6,097	4,096	-	2,001
Home Care STA	14,000	14,000	22,320	22,320
Project Hope - Planning	-	10,000	10,000	-
Project Hope - Youth Worker	3,750	3,750	-	-
Project Hope - Coordinator	40,000	-	13,497	53,497
Project Hope - Mobile Treatment	-	14,175	80,417	66,242
Project Hope - Outreach Services	-	-	20,368	20,368
Chief of Staff	-	-	60,000	60,000
Facility Assessment Audit	-	-	20,000	20,000
Total Sask Health	$ 904,158	$ 206,278	$ 515,998	$ 1,213,879
Non Sask Health Initiatives				
Cameco	500	500	-	-
SGI ABI program	11,741	11,741	-	-
Cognitive Disability	-	2,465	85,000	82,535
MCRRHA	19,609	-	-	19,609
Kids First North	1,000	1,000	-	-
Total Non Sask Health Initiatives	$ 32,850	$ 15,706	$ 85,000	$ 102,144
Total Deferred Revenue	$ 937,008	$ 221,984	$ 600,998	$ 1,316,023

6. Net Change in Non-cash Working Capital

	Operating Fund		Restricted Funds			
	2007	2006	Capital Fund	Community Trust Fund	Total 2007	Total 2006
(Increase) Decrease in accounts receivable	$ 193,484	$ (506,769)	$ 2,735,691	$ -	$ 2,735,691	$ (5,530,715)
(Increase) Decrease in due from capital fund	911,357	(721,725)	-	-	-	-
(Increase) Decrease in due from operating fund	-	-	(1,397,921)	-	(1,397,921)	-
(Increase) Decrease in inventory	150,240	(74,367)	-	-	-	-
(Increase) Decrease in prepaid expenses	(20,766)	(889)	-	-	-	-
Increase (Decrease) in accounts payable	216,239	108,933	623,914	-	623,914	1,155,942
Increase (Decrease) in accrued salaries	(272,367)	302,697	-	-	-	-
Increase (Decrease) in vacation payable	180,951	193,118	-	-	-	-
Increase (Decrease) in deferred revenue	379,015	(150,269)	-	-	-	-
Increase (Decrease) in due to capital fund	1,397,921	(34,530)	-	-	-	34,530
Increase (Decrease) in due to operating fund	-	-	(911,357)	-	(911,357)	721,725
	$ 3,136,074	$ (883,801)	$ 1,050,327	$ -	$ 1,050,327	$ (3,618,518)

7. Patient and Resident Trust Accounts

The RHA administers funds held in trust for patients and residents using the RHA's facilities. The funds are held in separate accounts for the patients or residents at each facility. The total cash held in trust as at March 31, 2007, was $1,645 (2006 - $1,110). These amounts are not reflected in the financial statements.

8. Related Parties

These financial statements include transactions with related parties. The Keewatin Yatthé Regional Health Authority is related to all Saskatchewan Crown agencies such as departments, corporations, boards and commissions under the common control of the Government of Saskatchewan. The Regional Health Authority is also related to non-Crown enterprises that the Government jointly controls or significantly influences. In addition, the Regional Health Authority is related to other non-Governmental organizations by virtue of its economic interest in these organizations.

a) Related Party Transactions

Transactions with these related parties are in the normal course of operations. Amounts due to or from and the recorded amounts of the transactions resulting from these transactions are included in the table below and the financial statements at the standard rates charged by those organizations and are settled on normal trade terms.

Accounts Payable	**2007**	**2006**
Saskatchewan Association of Health Organizations	$ 60,922	$ 1,738
Saskatchewan Property Management Corporation	39,662	34,094
Saskatchewan Health Employee Pension Plan	118,665	74,903
Saskatchewan Telecommunications	13,640	3,043
Saskatchewan Power Corporation	17,960	7,726
Saskatchewan Housing Corporation	-	8,570
Mamawetan Churchill River Regional Health Authority	97,278	82,540
La Loche Non-profit Housing Corporation	10,480	-
Ile a la Crosse Development Corporation	6,680	-
Prairie North Health Region	8,535	-
Saskatchewan Telecommunications Mobility	3,103	-

Expenses	**2007**	**2006**
Saskatchewan Association of Health Organizations	$ 584,413	$ 468,062
Saskatchewan Property Management Corporation	603,613	606,945
Saskatchewan Worker's Compensation Board	100,367	108,977
Saskatchewan Health Employee Pension Plan	1,089,172	1,017,699
Saskatchewan Telecommunications	157,283	204,980
Saskatchewan Power Corporation	122,288	117,479
La Loche Non-profit Housing Corporation	62,880	57,640
Public Employees Pension Plan	74,379	68,830
Saskatchewan Housing Corporation	101,010	119,221
Mamawetan Churchill River Regional Health Authority	82,838	85,540
Ile a la Crosse Development Corporation	80,160	-
Saskatchewan Telecommunications Mobility	37,448	-
Saskatchewan Registered Nurses Association	16,386	-
Prairie North Health Region	13,615	-

Accounts Receivable	**2007**	**2006**
Saskatchewan Health Northern Transportation	$ 44,426	$ 53,032
Saskatchewan Government Insurance	2,762	7,445

Revenue	**2007**	**2006**
Saskatchewan Health Northern Transportation	$ 263,657	$ 219,078
Saskatchewan Government Insurance	11,241	10,812

In Addition, the Regional Health Authority pays Provincial Sales Tax to the Saskatchewan Department of Finance on all its taxable purchases. Taxes are recorded as part of the cost of those purchases.

9. Comparative Information

Certain 2005-06 balances have been reclassified to conform to the current year's presentation.

10. Pension Plan

Employees of the RHA participate in one of the following pension plans:

1. **Saskatchewan Healthcare Employees' Pension Plan** (SHEPP) - This is jointly governed by a board of eight trustees. Four of the trustees are appointed by the Saskatchewan Association of Health Organizations (SAHO) (a related party) and four of the trustees are appointed by Saskatchewan's health care unions (CUPE, SUN, SEIU, SGEU, RWDSU, and HSAS). SHEPP is a multi-employer defined benefit plan, which came into effect December 31, 2002. (Prior to December 31, 2002, this plan was formerly the SAHO Retirement Plan and governed by the SAHO Board of Directors).

2. **Public Service Superannuation Plan** (a related party) - This is also a defined benefit plan and is the responsibility of the Province of Saskatchewan.

3. **Public Employees' Pension Plan** (a related party) - This is a defined contribution plan and is the responsibility of the Province of Saskatchewan.

The RHA's financial obligation to the plans is limited to making required payments to match amounts contributed by employees for current services. Pension expense for the year amounted to $ 637,347 (2006 - $568,620) and is included in benefits in Schedule 1.

Effective January 1, 2005, contribution rates are as follows:

6.552% (2006 - 6.552%) of pensionable earnings up to the yearly maximum pensionable earnings (CPP)
plus
8.232% (2006 - 8.232%) of pensionable earnings above the yearly maximum pensionable earnings (CPP)

11. Budget

The Regional Health Authority Board approved the 2006-2007 operating and capital budget plans on June 23, 2006.

12. Financial Instruments

a) Significant terms and conditions

There are no significant terms and conditions related to financial instruments classified as current assets or current liabilities that may affect the amount, timing and certainty of future cash flows. Significant terms and conditions for the other financial instruments are disclosed separately in these financial statements.

b) Credit risk

The Regional Health Authority is exposed to credit risk from the potential non-payment of accounts receivable. The majority of the Regional Health Authority's receivables are from Saskatchewan Health - General Revenue fund, Saskatchewan Workers' Compensation Board, health insurance companies or other Provinces. Therefore, the credit risk is minimal.

c) Fair value

The following methods and assumptions were used to estimate the fair value of each class of financial instrument:

- The carrying amounts of these financial instruments approximate fair value due to their immediate or short-term nature.

  cash and short term investments
  accounts receivable
  accounts payable
  accrued salaries and vacation payable

d) Operating Line-of-credit

The RHA has a line-of-credit limit of $500,000 (2006 - $500,000) with an interest charged at prime, which is re-negotiated annually. The line-of-credit is non-secured. Total interest paid on the line-of-credit in 2007 was $836 (2006 - $801). This line-of-credit was approved by the Minister in 1999.

13. Volunteer Services

The operations of the Keewatin Yatthé Regional Health Authority utilize services of many volunteers. Because of the difficulty in determining the fair market value of these donated services, the value of these donated services is not recognized in the financial statements.

14. Contingent Liability

a) The joint job evaluation/pay equity initiative for the service provider unions CUPE, SEIU, and SGEU allowed for an appeal process. Although the Reconsideration Committee has completed their recommendations, there still remain a number of outstanding bundling issues. A financial obligation to pay reconsideration/bundling costs occurs once the JJE Dispute Resolution Tribunal reviews the recommendations from the Reconsideration Committee and reaches a consensus decision. The specific details of the process to deal with these bundling issues are presently being negotiated between the respective unions and SAHO. The results of outstanding reconsideration/bundling issues are currently unknown therefore, the costs cannot be reasonably determined.

b) The Region has been named as defendant in a lawsuit on behalf of "La Loche Physician Group", seeking to recover damages allegedly sustained by them as a result of a contract termination. The complaint with respect to this action generally alleges the Region breached its contract with them. The Region has filed a defence to the claim, and mediation of the claim must take place before any further steps are taken. These lawsuits remain at an early stage and, as litigation is subject to many uncertainties, it is not possible to predict the ultimate outcome of these lawsuits or to estimate the loss, if any, which may result.
The Region's insurers have been advised of these claims and are cooperating with the Region in the defence of these lawsuits subject to policy deductibles, limits, and terms and conditions.

c) The Region, for recruitment purposes has provided a mortgage guarantee on the "Health Care Personnel Complex" owned by the Village of Ile a la Crosse. The guarantee requires the Region to pay any rental shortfall resulting from the complex having less than 100% occupancy. During the year the Region paid $0, (2006 – $0) as a result of this guarantee and included this amount in the statement of operations as supplies and other expenses.

KEEWATIN YATTHE REGIONAL HEALTH AUTHORITY
SCHEDULE OF EXPENDITURES BY OBJECT
For the Year Ended March 31, 2007

	Budget 2007	Actual 2007	Actual 2006
Operating:			
Board costs	$ 190,700	$ 144,735	$ 161,916
Compensation - Benefits	2,171,039	2,186,103	2,035,255
Compensation - Salaries	12,453,604	12,829,661	12,436,349
Diagnostic imaging supplies	18,800	12,195	18,495
Drugs	182,222	201,495	181,463
Food	177,079	183,420	172,060
Grants to ambulance services	-	-	-
Grants to third parties	132,000	140,000	132,000
Housekeeping and laundry supplies	129,466	128,141	88,896
Information technology contracts	11,879	10,933	8,452
Insurance	57,813	66,262	67,823
Interest	785	1,960	2,549
Laboratory supplies	120,500	131,250	129,613
Medical and surgical supplies	224,703	210,743	208,091
Medical remuneration and benefits	257,594	562,046	742,141
Office supplies and other office costs	467,041	296,492	330,654
Other	971,128	1,891,235	1,900,070
Other referred out services	13,000	20,738	63,269
Professional fees	92,187	143,706	80,166
Prosthetics	-	-	-
Purchased services	147,719	206,664	122,843
Rent/lease costs	688,935	801,347	817,197
Repairs and maintenance	117,454	177,759	116,817
Service contracts	112,500	56,016	369,809
Travel	369,428	439,086	424,644
Utilities	339,995	301,463	329,791
	$ 19,447,571	$ 21,143,450	$ 20,940,363
Restricted:			
Amortization		$ 627,362	$ 742,865
Loss/(Gain) on disposal of fixed assets		(66,668)	-
Other		-	-
		$ 560,694	$ 742,865

KEEWATIN YATTHE REGIONAL HEALTH AUTHORITY
SCHEDULE OF INVESTMENTS
For the Year Ended March 31, 2007

	Amount	Maturity	Effective Rate	Coupon Rate
Restricted Investments*				
Cash and Short Term				
Chequing and Savings:				
Battleford Credit Union	$ 369,669		4.00%	
	369,669			
Term Deposits:				
Battleford Credit Union	-			
	-			
Total Cash & Short Term Investments	369,669			
Long Term				
Total Long Term Investments	-			
Total Restricted Investments	**369,669**			
Unrestricted Investments				
Cash and Short Term				
Chequing Battleford Credit Union	3,826,738		1.00%	
Chequing Bank of Montreal	85,482			
Term Deposit BCU	200,000		2.95%	
Petty Cash	1,026			
Total Cash & Short Term Investments	4,113,246			
Long Term				
Unite Pharmacist Share	-			
Total Long Term Investments	-			
Total Unrestricted Investments	**4,113,246**			
Total Investments	**$ 4,482,915**			
Restricted & Unrestricted Totals				
Total Cash & Short Term	$ 4,482,915			
Total Long Term	-			
Total Investments	**$ 4,482,915**			

KEEWATIN YATTHE REGIONAL HEALTH AUTHORITY
SCHEDULE OF INTERNALLY and EXTERNALLY RESTRICTED FUNDS
For the Year Ended March 31, 2007

INTERNALLY RESTRICTED FUNDS

	Balance, Beginning of Year	Revenue	Investment Income	Transfer to Investment in Capital Assets	Balance, End of Year
Ile a la Crosse Facility	$ 5,138,371	$ 6,985,290	$ 3,996	$ (8,035,618)	$ 4,092,039

EXTERNALLY RESTRICTED FUNDS

	Balance, Beginning of Year	Investment & Other Income	Capital Grant Funding	Expenses	Transfer to Investment in Capital Assets	Balance, End of Year
Ile a la Crosse Facility	$ 251,000	$ 9,551	$ -	$ -	$ -	$ 260,551
TOTAL EXTERNALLY RESTRICTED REVENUE	**$ 251,000**	**$ 9,551**	**$ -**	**$ -**	**$ -**	**$ 260,551**

SCHEDULE 4

KEEWATIN YATTHE REGIONAL HEALTH AUTHORITY
CONSOLIDATED SCHEDULES OF

BOARD MEMBER REMUNERATION
for the year ended March 31, 2007

RHA MEMBERS	RETAINER	PER DIEM	TRAVEL TIME EXPENSES	TRAVEL AND SUSTENANCE EXPENSES	OTHER EXPENSES	CPP	2007 TOTAL	2006 TOTAL
Chair Person								
David Seright	$ 8,508	$ 10,750	$ 4,514	$ 10,523	$ -	$ 756	$ 35,050	$ 18,029
Rose Daigneault	-	-	-	-	-	-	-	20,469
Members								
Gloria Apesis	-	2,400	1,825	3,467	-	209	7,901	14,302
Lester Herman	-	2,875	1,909	4,149	-	237	9,170	6,631
John Janvier	-	4,725	2,548	5,277	-	360	12,910	18,321
Stella Lalberte	-	3,675	1,913	3,989	-	277	9,853	15,939
Yvette Morin	-	1,600	325	502	-	95	2,523	2,292
Louis Morin	-	-	-	-	-	-	-	11,153
Annette Montgrand	-	4,075	2,734	6,071	-	337	13,218	14,488
Dorah Montgrande	-	6,100	3,263	6,561	-	463	16,387	13,471
Arthur Daigneault	-	4,525	3,324	7,149	-	-	14,998	214
Duane Favel	-	5,525	3,473	6,553	-	445	15,996	3,294
Tina Rasmussen	-	3,100	1,748	3,053	-	240	8,141	11,980
Ross MacLeod	-	-	-	-	-	-	-	14,958
TOTAL	**$ 8,508**	**$ 49,350**	**$ 27,576**	**$ 57,294**	**$ -**	**$ 3,419**	**$ 146,147**	**$ 165,541**

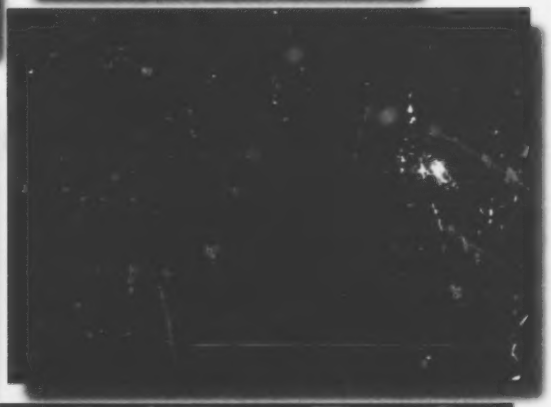
KEEWATIN YATTHE REGIONAL HEALTH AUTHORITY **SCHEDULE 4A**
CONSOLIDATED SCHEDULES OF

SENIOR MANAGEMENT SALARIES, BENEFITS, ALLOWANCES, AND SEVERANCE
for the year ended March 31, 2007

	2007					2006		
Senior Employees	Salaries[1]	Benefits and Allowances[2]	Sub-total	Severance Amount	Total	Salaries, Benefits and Allowances	Severance	Total
Carol Gillis, CEO	$ 103,726	$ 1,274	$ 105,000	$ -	$ 105,000	$ 97,945	$ -	$ 97,945
Denise Desjarlais, Quality Care	69,549	2,808	72,357	-	72,357	61,416	-	61,416
Gabrielle Fontaine, Quality Care, Beginning March 5, 2007	4,214	196	4,410	-	4,410	-	-	-
Elaine Malbeuf, Director of Community Based Services	79,589	3,391	82,980	-	82,980	74,184	-	74,184
Lloyd Bullock, Director of HR, ending Sept 30/06	37,274	6,175	43,449	-	43,449	85,918	-	85,918
Wendy Ericson-Lemaigre, Director of HR, Beginning Dec. 1/06	26,045	784	26,829	-	26,829	-	-	-
Pat Malmgren, Director of Primary Health	99,486	5,516	105,002	-	105,002	97,001	-	97,001
Richard Petit, Director of Corporate Services	78,681	2,548	81,229	-	81,229	75,149	-	75,149
Zachery Solomon, Director of Finance	66,910	1,862	68,772	-	68,772	75,150	-	75,150
Total	$ 565,474	$ 24,554	$ 590,028	$ -	$ 590,028	$ 566,763	$ -	$ 566,763

(1) Salaries include regular base pay, overtime, honoraria, sick leave, vacation leave and merit or performance pay, lump sum payments, and any other direct cash remuneration.

(2) Benefits and allowances include the employers share of all employee benefits and contributions. This includes car allowance, education and training, professional membership fees, other fees, and relocation costs.



Payee Disclosure List

As part of the government's commitment to accountability and transparency, the Department of Health and Regional Health Authorities disclose payments of $50,000 or greater made to individuals, affiliates, and other organizations during the fiscal year. These payments include salaries, contracts, transfers, supply and service purchases and other expenditures.

Keewatin Yatthé Health Region's 2006-2007 Payee Disclosure List can be accessed at **http://www.health.gov.sk.ca/**

Keewatin Yatthé Regional Health Authority
Payee Disclosure List
For the Year Ended March 31, 2007

Personal Services

Listed are individuals who received payments for salaries, wages, honorariums, etc. which total $50,000 or more.

AGUINALDO, ROSALINA	181,320
BALONE, FRED	126,067
BODNARUS, CARLA	55,232
BRUNELLE, ELIZABETH	99,898
BUCHKOWSKI, KRISTY	52,673
CAISSE, SHELLY	72,081
CAL, MAXINE	54,925
CHRISTENSON, CHRIS	64,990
CLARKE, IRIS	57,951
CLARKE, SANDRA	62,902
CORRIGAL, ANNA	66,287
DAIGNEAULT, ROBERT	57,173
DE LOS REYES, SONIA	192,902
DESHARNAIS, SIMONNE	110,105
DESJARLAIS, DENISE	69,549
DILLER, RON	74,406
DUBRULE, ROBERT	73,296
DUROCHER, DOROTHY	60,891
DUROCHER, MARLENA	92,795
DUROCHER, PETER	64,708
ECHAVEZ, MARILOU	134,950
ELLIOTT, HILDA	52,275
FORDE, MAUDLIN	67,109
GARDINER, MELANIE	54,203
GILLIS, CAROL	103,726
HANSEN, CINDY	53,364
HANSON, JOLENE	50,845
HEAD, CANDICE	68,462
HERMAN, DEAN	69,408
HERMAN, SIMONE	56,482
HURD, SHELLY	66,573
IRON, TERRANCE	92,469
JANVIER, CAROL	58,510
JANVIER, EDWINA	50,593
KELLER, GRACE	146,615
KISSICK, MARGARET	67,592
KOSKIE, MEGAN	71,381
LAFLEUR, LEANNE	59,606
LANGGAM, LOU SYLVE	111,893
LARIVIERE, ANN	93,534
LEMAIGRE, ANTOINETTE	63,010
LEMAIGRE, CAMERON	55,285
LEWIS, DARREN	60,618
LISTOE, EILEEN	52,131
MALBEUF, ELAINE	79,589
MALMGREN, PATRICIA	99,486
MCGAUGHEY, CALVIN	65,543
MCMILLEN, JANICE	90,290
MCWILLIAMS, MINDY	74,097
MIDGETT, LORI	83,952
MONTGRAND, GLENDA	56,920
MORIN, IDA	89,699
MOSS, ANDRE	66,860
MOYNAGH, MAUREEN	68,998
MUENCH, LYLA	64,313
MUNSTERS, EDITH	70,883
PALMIER, DEANNA	73,750
PAUL, VIRGIL	58,300
PEDERSEN, LINDA	50,320
PERREAULT, ARMANDE	59,307
PETIT, RICHARD	78,681
REDIRON, SANDY	94,344
RIEMER, ANN	52,673
ROMANOW, MARK	55,539
ROY, LOUIS	58,396
SAN JUAN, MARICEL	70,391
SERIGHT-GARDINER, PEARL	106,002
SHEWCHUK, JANET	68,241
SOLOMON, ZACHERY	66,910
SOLOSKI, ADOLPH	53,793
ST. PIERRE, PRISCILLA	57,726
SUMAKOTE, EVELYN	77,864
TINKER, PHYLLIS	92,131
UMPHERVILLE, WANDA	52,303
WAGENAAR, MATHILDA	52,550
WALLACE, ROBIN	103,101
WELSH, BONNIE	110,581
WELWOOD, MICHAEL	65,144
WILKINSON, RYAN	57,738

Supplier Payments

Listed are payees who received $50,000 or more for the provision of goods and services, including office supplies, communications, contracts, and equipment.

ABBOTT LABORATORIES CANADA - CA	54,741
AODBT INTERIOR DESIGN	235,103
CPDN	103,791
D.L.P. CONSULTING LTD.	107,655
FEDERATED CO-OPERATIVES LTD.	130,107
GRAHAM CONSTRUCTION & ENGINEERIN	7,346,596
HENRY SCHEIN ASH ARCONA	64,001
HOSPIRA HEALTHECARE CORP	78,235
HUMAN RESOURCES SERVICES LTD.	66,984
ILE A LA CROSSE DEVELOPMENT CORP	73,480
JOHNSON & JOHNSON MEDICAL PRODUC	82,318
LA LOCHE NON-PROFIT HOUSING CORP	62,880
M.D. AMBULANCE CARE LTD.	86,043
MAMAWETAN CHURCHILL RIVER REGION	180,116
MCKESSON CANADA	104,665
MEADOW LAKE TRIBAL COUNCIL	90,000
METIS LOCAL #62	50,409
MINISTER OF FINANCE	280,189
MINISTER OF FINANCE	277,089
NORTH SASK LAUNDRY	89,425
NORTH WEST AGENCIES	60,546
POLAR OILS LTD.	125,743
PUBLIC EMPLOYEES PENSION PLAN	56,113
SAHO	106,073
SAHO- CORE DENTAL PLAN	96,554
SAHO-DISABILITY INCOME PLAN	115,712
SAHO-I/S EN DENTAL EX HEALTH PLA	241,575
SASK HEALTHCARE EMPLOYEES PENSIO	1,132,933
SASK. HOUSING CORPORATION	97,340
SASK. POWER	122,595
SASKATCHEWAN WORKER'S COMP BOARD	251,327
SASKTEL	157,853
SCHAAN HEALTHCARE PRODUCTS	119,295
SGEU	75,965
SGEU - LTD	57,614
SOURCE MEDICAL	53,376
SYSCO SERCA FOOD SERVICES INC.	159,881
THAKORE SHAFALI	53,480
THE GREAT WEST LIFE ASSURANCE CO	73,410
THE NORTH WEST COMPANY	239,560
THE RECEIVER GENERAL FOR CANADA	4,046,201
UNITED PHARMACIST ENTERPRISE	1,247,771

ACCOLADES

In appreciation and acknowledgement of their many years of commitment and service, a long service award was presented by the Keewatin Yatthé Regional Health Authority Board and Management to the employees listed below during a recognition ceremony in November 2006.

Pictured above: KYRHA long service award recipients at the recognition awards presentation ceremony, La Loche Health Centre.

5 years service

Mildred Janvier
Kevin Herman
Harvey Montgrand
Glenda Robson
Antoinette Lemaigre
Vanessa Janvier
Lynn Morin
Beatrice Piche
Marie E. Bouvier
Shelly Hurd
Ron Diller
Joseph McCallum

7 Years Service

Denise Desjarlais

10 Years Service

Francoise Paul
Patricia Laliberte
Yvonne Kimbley
Carol Janvier
Flora Niultcho

15 Years Service

Shirley Laliberte
Glenda Montgrand

20 Years

Beatrice Maurice

25 Years

Suzanne Aubichon
Clara Moise
Hilda Elliot
Dorilda Piche

30 Years

Margaret Roy
Victoria Dore

Brighten Your Corner

~By Helen Steiner Rice

We cannot all be famous or be listed in
"Who's Who",
But every person great or small,
Has important work to do.

For seldom do we realize the importance
of small deeds,
Or to what degree of greatness
Unnoticed kindness leads.

For it's not the big celebrity in a world of
fame and praise,
But it's doing unpretentiously
In an undistinguished way.

It is the work that we're assigned, unimportant as it seems,
That makes our task outstanding,
And brings reality to dreams.

So do not sit and idly wish for wider new
dimensions
Where you can fantasize about
Your many good intentions.

But at the spot you are right now begin at
once to do
Little things to brighten up
The lives surrounding you.

If everybody brightened up the spot
where they are standing,
By being more considerate,
And a little less demanding,

This dark old world would very soon
eclipse the evening star,
If everybody brightened up
The corner where they are!

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